Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROBERT, KELLEY 8:08 PM AUGUST 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIV. OF MARYLAND BALTIMORE CITY MEDICALCTA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Bay), 1951 5. Social Security Number 7. Age (In yrs. last birthday) 56 Yrs 6. Sex 9. Birthplace (State or Foreign Months **X**□ M 2 □ F Texa's 454-90-7243 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No PA York Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1075 Beaver Creek Road 17331 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give 1970—1994 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🕍 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Non-Commissioned Officer US Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgia Nell Knesek Edward Kelley, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1075 Beaver Creek Road, Hanover, PA 17331 Linda Kelley, Wife 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State Cremation Direct Srvc. 08/30/2008 York, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Censee M01113 22. Name and Address of Facility Panebaker Funeral Home 311 Broadway, Hanover, PA 17331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GRAFT VERSUS HOST DISTAGE Due to (or as a consequence of): MYELOGENOUS Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner the death certificate be executed P.O. Division of Vital Records, After

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

29a. Certifier

(Check only

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination to the programment of the medical Examination.

Physician

Baltimore, Maryland 21215-0036

sician and burial-tran physician the burial nse fo signed by the a Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: /

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDRA QUEZADA

M.D. 32, Registrar's Signature

M.D.

1990 13

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

South Greene Street Baltmore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician CANE 7:13 Pm SEPTEMBER 02, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N HOSP ITAL ALTMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Jast birthday) 6. Sex 7. Age (In yrs. Funeral Months 1 □ M 2 🗹 E march 30 Director Usua! Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 2 No md. **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Deamon 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☑ No. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) omes College,(1-4or 5+) 00 Se 2th NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mabe Jaine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 804 avinja Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral S 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or near failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) DAYS Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

JEG AYEHU

SEP 05

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REFE

M3 LLOW FAILD

32. Registrar's Signature

29c. License number

30015

001

Hanover

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Conies Are Legible.
amend items 7,19b,20c per 1h g883 9-12-08 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 28503 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month U4 **Physician** NANBARET 0020 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Hospice of Chesapeake Harwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Davs 1 M 2 F 99 Months Hours Min. Yrs 01-07-1909 Director 191-36-0806 Hungary Usual Residence of Decedent 10c. City, Town or Location or 28a-f show notified at 10a. State 10h. County 10d. Inside City Limits 1 XX es 2 □ No Director Maryland | Anne Arundel <u>Annapolis</u> the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re death with U.S.A. 1392 Stonecreek Road 21403 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0036 Specify. Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) <u>School Teacher</u> Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Segal ၉ Rose Klein Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
214 S. Southwood Avenue
220 Wintergull Lane, Annapolis, Md. 21409 21401 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is Department of Health Important: If item 27 any Injury or other tra Robert Libson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pittsburgh 4 □ Donation 5 □ Other (Specify) 9/3/2008 West View Cemetery 21. Signature of Fineral Sen 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachyline. Immediate Cause (Final art **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Veal Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has be rector, page 2 s Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence Cherk (Specify) HOUSE 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Iniury 5 Pending S after dea...
seral Director: A'
villed in by the 1 ☐ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 lember 01, 2008 who combleted cause of death (Item 23a) (Type, Print) 30. Name and address of person MOHWAY ANNAPOUS MD 21401 E MILHAGI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Doris Ruby Lasky 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. If Under 1 Yea Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Year) 1 □ M 2 F Days Hours Min. Months 83 5-4-1925 219-14-7699 Md. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Balto. Perry Hall 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18 Brookfarm Ct. Unit D 21128 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 □Yes 2 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No White Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel R. Fox Katherine M. Firoved 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. McCloskey DTR. P.O. Box 115 Manchester, Md 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9-3-2008 Mt. Hope Frederick, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medical Examiner

Department of Health and Mental Important: If Item 27 Is marked of any injury or other traumatic ever

Baltimore,

permit.

Physician

/Medical

Examiner

Md.

Director

Funeral

Completed by

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

ng physician and as the burial-transit attending p signed by the a

The law requires that the death certificate be exect Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifit
completely filled in by the funeral director, To the I within 2.

| | Immediate Cause (Final disease or condition resulting in death) | a. METASTA1 Due to (or as a consequence) | | IOCARCINO. | nA | | Onser and Death |
|---|---|---|---|--|--|--|--|
| cal Examiner | Sequentially list conditions, if any, leading to initiodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Dus to (or as a consequence of the consequence | , | | | | |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of 9 | al death 3 🗆 Ectopi | c pregnancy (specify) | | 23d. Date of de Month | elivery Day Year |
| ed by Pł | Part II. Other significant conditions of | contributing to death but not res | ulting in the underlyin | g cause given in Part I. | 23e. Did tobacco | | o the cause of death? Probably 4 \(\sum \) Unknown |
| Complet | | | | | 24a. Was an - autopsy performed? 1 □ Yes 2 ☑ | prior to death? | utopsy findings available completion of cause of s 2 \(\subsection \) |
| Be | 25. Was case referred to medical | | | 26. Place of D | eath (Check only one) | | |
| | examiner? 1 ☐ Yes 2 🕱 No | Hospital: 1 npatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing | Home 5 ☐ Residence | 6 ☐ Other (Spe | ecify) |
| ation: | 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation | | 28b. Time of Injury | 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how in | jury occurred | |
| Medical Certification: To | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At h building, etc. (Speci | ome, farm, street, fact | cory, office | 28f. Location (Street City or Town, Sta | and Number or Rate) | tural Route Number, |
| edical (| 29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam | nysician: To the best of my knowniner: On the basis of examination and manner stated. | owledge, death occur ation and/or investigat | red at the time, date and plation, in my opinion, death oc | ace, and due to the cause courred at the time, date a | e(s) and manner a and place, and du | as stated. e to the cause(s) |
| M | 29b. Signature and title of certifier | | | 29c. License number | 29d. [| Date signed (Mon | th. Dav. Year) |

29c. License number

D0065094

9000 FRANKLIN SQUARE DRIVE BALTIMORE, MARYLAND 21237

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

30. Name and address of per DR. NGUYEN BINH

31. Date filed (Month, Day,

Year)

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 9-3-2008 8:00A James F. Lucido /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. 4907 Marchwood Ct. Perry Hall If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year, 6-11-1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2 □ F Months Md . 77 Director 212-30-1560 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Md. Balto. Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21128 USA 4907 Marchwood Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Water Dept. 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked of Theresa Liberto Samuel Lucido 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Marchwood Ct. Perry Hall, Md. 21128 Wife Rosaria Lucido 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 9-6-2008 Timonium Dulaney Valley 4 Donation 5 Dother (Specify) Schimunek Funeral Home 21. Signature of Funeral Service Lice see 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final 5 years **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran Division of Vital Records, P.O. Box 68760< Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 to No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To this the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 rear **Physician** 5:25 August 26, Ам Lee Lindenmuth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Abingdon 2812 Preston Lane 8. Date of Birth (Month, Day, Ye Feb. 10, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Year) 1939 Maryland 69 **Director** 219-36-0923 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at 1 □Yes 2 ₩ No Director Harford Abingdon Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21009 2812 Preston Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, Ite Many injury or other traumatic event, Ite Many injury or other traumatic event, Ite Many injury or other traumatic Elementary/Secondary (0-12) College (1-4or 5+) Feeding Company 12 Warehouse Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 Lindenmuth Mary Louise ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2812 Preston Lane Abingdon, MD 21009 Mary Ellen Lindenmuth (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem'l Gdns. 8/29/2008 Bel Air 4☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licens 000 610 W. Macphail Rd. Bel Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER au ung Years disease or condition resulting in death) /Medical Due to (or as Consequence of): Examiner Sequentially list conditions, it is a list conditions, it is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Ö 1 Tyes 2 No. been signed by the should be detached 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? ✓ 24a. Was an After this certificate has funeral director, page 2 s autopsy The performe 2 XNO 1 ☐ Yes 2 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No reral Director: , filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere AUR. BAltinove 1717 2/2/5 Ste 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

| | | For State of Maryland / Department / Departmen | ent of Health and Mental Hygiene 2008 28507 |
|--|------------------|--|--|
| | | Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year 3. Time of Death |
| Physici /Medic | | Mary M. Lowry | Sept 3, 2008 12:45PM |
| Examin | er | , , | ity, Town, or Location of Death Indalk 4c. County of Death Baltimore |
| Funeral Director | | | der 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign |
| w w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| Marylan -f show | ţō | MD Baltimore Dundalk | 1. ŽŠYes 2 □ No |
| h with the 23a or 28a | Funeral Director | 10e. Street and Number 258 Baltimore Avenue | Zip Code 10g. Citizen of What Country? USA |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be medified at once. | by | 1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 No | cedent of Hispanic Origin? (Specify Yes or Nopecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White |
| thin 72 hours | Completed | Elementary(Secondary (0-12) College (1-4or 5+) | work done during most of working Tuse retired) |
| led wil hygien her th | | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| d be filk ental H ced oth | o Be | Frank E. Towsend | Lydia S. Baumes |
| and 2 should be eath and Mental n 27 is marked oner traumatic every | 2 | 19a, Informant's Name/Relationship (Type, Print) 19b, Mailing Addr | ess (Street and Number or Rural Route Number, City or Town, State, Zip Code) ltimore Avenue, Dundalk, MD 21222 |
| ss 1 ar of Hea of Hea r othe | | 20a. Method of Disposition 20b. Place of Disposition (| Name of Date 20c. Location - City or Town, State or other place) |
| Pages ment of lant: If Its jury or o | | 4 Donation 5 Other (Specify) Bayview Cr | ematory 9-4-08 Baltimore, MD |
| permit. Pages Department of Important: If I any Injury or | | Bellah PA, | e and Address of Facility Bradley-Ashton Funeral Hom 2134 Willow Spring Road, 21222 |
| | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart fallure. List only one cause on each line. | Onset and Death |
| Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Wetustutu Srecust Due to (or as a consequence of): | Cancer 20415 |
| Examiner | | | |
| p it | iner | Sequentially list conditions, it is not because Enter Underlying Cause (Disease or injury that initiated events c. | |
| ficate be executed physician and s the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last C | |
| cate be exphysician the burial | dical E | d | |
| tifficate ng phy as the | | - u. | |
| Physician: The law requires that the death certificate has been signed by the attending or this certificate has been signed by the attending or this certificate has been signed by the attending or the constant of the const | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Other | oic pregnancy (specify) 23d. Date of delivery Month Day Year |
| ned by | by Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying | ng cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |
| law requires t as been signe 2 should be | | 1 Diabetes Mellitos | 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown |
| ding Physician: The law requir h. Affer this certificate has been s funeral director, page 2 should | Completed | | 24a. Was an autopsy autopsy performed to autopsy performed to the prior to completion of cause of death? 1 □ Yes 2 □ No |
| vital iclan: 1 certifical ector, pa | Be (| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one |
| Physical this caral direction | ၉ | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of | |
| ng ng | tion | 1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation M | 28c. Injury at Work? 1 □ Yes 2 □ No |
| al or Attending after death. I Director: After din by the fune | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the | edical | | rred at the time, date and place, and due to the cause(s) and manner as stated. ttion, in my opinion, death occurred at the time, date and place, and due to the cause(s) |
| To the Committee | M | 29b. Signature and title of certifier | 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) |
| K | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | D39460 Sept. 3, 2008 |
| Sta Regist | | 31. Date filed (Month, Day, Year) SEP 0 5 2008 32. Fegistrar's Signature | le l |

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day LOOSE 3:04 PM OBERT 08 september 03 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPITAL BALTIMORE if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/22/1944 If Under 1 Year Birthplace (State or Foreign Country) 218-44-4728 Months Days Hours MD Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Nes 2 No 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 442 East Clement Street 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No Amy If Yes, Give 1964–1969 Year or Dates:1964–1969 1 ☐ Never Married 2 X Married Specify: White 1 ∐Yes 2. ŽNo Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Fork Lift Operator Domino Sugar 17. Father's Name (First, Middle, Last)
Frederick Loose 18. Mother's Name (First, Middle, Maiden Surname) Loose Katherine Loris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Geraldine C. Minento 442 East Clement Street, Baltimore, MD 21230 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 09/08/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

Charles L. Stevens Funeral Home Inc. 21. Signature of Funeral Service Licensee Victor P. Doda 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): PNEUMO NIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) LIVER Due to (or as a consequence of) RDS 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) I∐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

Examiner

Funeral

Director

show

d other than "natural", or items 23a or 28a-f shevent, the Medical Examiner must be notified

permit, Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Item Medic once.

filed within 72 hours after death with

Saltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

à

Completed

Be

ပ

Examiner attending physician and for use as the burial-trar Physician/Medical signed by the a \$ Completed cate has b e Hospital or Attending Physician: The 124 hours after death.
e Funeral Director: After this certificate h letely filled in by the funeral director, page Be

Certification: To

Medical

completely

the within 2 To the IF FEMALE:

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

Inpatient Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred 1 □Yes 2 □No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

BALTIMORF

29b. Signature and title of certifier

5 Pending investigation

6 □ Could not be

M.D.

and manner stated.

STREET

29c. License number

BEPTEMBER 03, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALBAR 200 BOUTH

HAVEEN 31. Date filed (Month, State

32. Registrar's Signature Day, Year) 2008 SEP O 5

DHMH 17 Rev 1/2001

Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28509 Reg. No.2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** :30 AM 0 2008 ର ୪ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NP If Under 1 If Under 24 Hrs. 8. Date of Birth Hours Min. 1 Month, Day, irgi 6. 30 s last birthday) Birthplace (State or Foreign Country) 7. Age (In y **Funeral** Year) Months -30-5728 1**2** M 2 □ F Jersey Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at ¥Yes 2 No Director imore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 0 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📉 vo Specify Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eldersb Elementary/Secondary (0-12) College (1-4or 5+) Driver ldin NIA s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau celin Tre. Ba , mdi 3016 inia ogan 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) waster 22. Name and Address of Facility 21. Signature of Funeral Service Lio saref. march 23a. Part 1.7 n er the disease, or complications that caused the shock, heart failure. List only one cause on each line. Approximate Interval Between poset and Death lea h. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate / ause (Final disease | condition resulting in death) mantho **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause () lists of i jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician at the burial Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar signed by the a 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown has been si e 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate of Vital 1 ☐Yes 2 € or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death,

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and titlerof certifier and and ress of er on who completed cause

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

SEP 05

32 Registrar's Signature

Amend Please Type or Print in Black indelible Ink, 4708 Tr

State of Maryland / Department of Health and Mental Hygiene Occupants

Certificate of Death 28510 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month MASON CAROLYN 2004 M 08 25 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SILVERSPRING MONTGOMERY CENTER LAYHILL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Months Days Hours Yrs 55 Director 215-60-8615 6/23/1953 Jackson, Tenn Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23s or 28s-f show the Wedical Examinar must be nutified at XXYes 2 □ No **Funeral Directo** Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3227 Bel Pre Road 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ANO Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Relations Assistant Pages 1 end 2 should be filed w then of Health and Mental Hygie tent: if Item 27 is marked other ti jury or other traumatic event, In Private 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) ပ Abner Columbus Mason Elois Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5706 Parkway Drive Laurel, Maryland 20707 Rosemary Botchway / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State -29-08 Metropolitan Crematory permit. Page Depertment of Importent: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. Signature of Funeral Service Liennsee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PERSISTENT VEGETATI VE **Physician** /Medical Due to (or as a consequence of): Examiner Seizure disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDI Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MOIND been si 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown CONTRACTURES; Alcohol Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate s after deeth.
el Director: After this certificate ed in by the funeral director, pt Abdominal wound due to fistula @ PEG tube site 2□ No 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 □ Yes 2 □ No investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) man M.D D0064208 08 30. Name and address of person who completed cause of death (Item 23a) (T. pe, Print) SILVERGRING MD. SAADIA BELPRE ROAD HUSALN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 04 2008 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Manth 2-2008 **Physician** 2:35P Lena M. Moler /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Balto. Hunt Valley Masonic Home 9. Birthplace (State or Foreign County) 8. Date of Birth (Month Day Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Days Months 1 ☐ M 2 👿 F 216-22-5205 99 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Balto. Perry Hall Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21128 9504 Amberleigh Lane Unit M Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Maryland 21215-0036 Specify ģ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker Hnknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Helen M. Humphrey Ross Wenner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9504 Amberleigh Lane Unit M Perry Hall, Md. 21128 Gary Moler Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-4-2008 Balto. 21 Signature of Funeral Service Liquises 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md.21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Evel Due to (or as a consequence of): /Medical Examiner Cerelio Vasala Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has l autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this After this funeral c 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Vear) Division To the Hospital or Attending (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d Date signed (Month, Day, Year) Ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3508 103cm KO BENT mD 31. Date filed (Month, Day, 32. Pegistrar's Signature Year) State SEP 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 00027 1 2, 2008 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Franklin Square
5. Social Security Number 6. Sex Hospital Cente 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday **Funeral** 215-30-2602 1 □ M 2 🗓 F Months Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner institute to nother at 1 ☐ Yes 2 No Director CJARAL O 10e. Street and Number 10g. Citizen of What Country? 31336 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2¶ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr Nottingham Man Moudre CLM 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility ANDERZOA KAPI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYPOKIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** NBUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Physician/Medical as the for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CONCESTIVE HEART RA1 CURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed DISEASE OBSTRUTIVE CHRONIC 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 24 hours after death. Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Offm no 055356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore MD. 21237 Registrar's Signature OR Denni 5 31. Date filed (Month, Day, Ye

DHMH 17 Rev 1/2001

State

Registrar

Year)

とうにな

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per FH 6883 9 11 08 TT State of Maryland Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 08-126-2008 Physician 815 р м Lillian Elizabeth Magliano /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 164 Cree Terrace Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **8/27/**(Month, Day, Year)

08-20-1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 □ F 214-14-9475 89 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Instit: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Funeral Director MDCecil Rising Sun 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 164 Cree Terrace 21911 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vogel Harry Dasch, Sr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 164 Cree Terrace Rising Sun, MD 21911 Tony Magliano (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-30-2008 Baltimore, MD Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service vicensee Schimunek Funeral Homes Inc. 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiom, onthe **Physician** congestive ears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading limit fair cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical signed by the attending p I be detached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 s autonsy perform 1∐ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 25(No Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deal 1 Accident 5 Pending investigation 1 ☐ Yes neral Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral C

completely filled i

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

101 COLOMAI M Deil E Lettin 31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ORIGINAL

000283

29d. Date signed (Month, Day, Year)

1 - For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Felicia C. Mangione

DHMH 17 Rev 1/2001

| | Examin | er | 4a. Facility Name (Stella | | give street and n | umber) | | | Town, or Lmoni | Location | of Death | | 4c. Co | unty of Deat Ba | lto. | |
|--------------------------------|---|-------------------|--|------------------------------|---|---|----------------------------------|--|--------------------------------------|---------------------------------|--------------------------|--|------------------------------|--|--|--|
| | Funeral Director | | 5. Social Security N | lumber | 6. Sex 1 □ M 2 A F | 7. Age (In y | rs. last birthday Yrs. | | 1 Year Days | | 24 Hrs. Min. | 8. Date of Birt (Month, Da 3-12- | h y, Year) 1911 | Co | hplace (State or Foreign untry) Md • | |
| | | | Usual Residence of | | | | | | | | | | | | | |
| | irylan show | _ | 10a. State | 10b. County | | 10c. | City, Town or L | ocation | | | | | | | 10d. Inside City Limits | |
| | r 28a-f show | ecto | Md. | 1 | alto. | | N | otting | | | | | 10a Citiana | of Mile at Ca | 1 □Yes 2 □ No | |
| | ath with the 23a or 2 ust be n | Funeral Director | 1 Tread | | | | | 10f. Zip | 212 | 236 | | | rug. Citizer | of What Co USA | untry? | |
| | r deat | ner | 11. Marital Status | | Armed F | cedent Ever in | U.S. 13 | . Was Dece If Yes, spe | dent of H | ispanic Oi n, Mexica | rigin? (Spe | ecify Yes or No Rican, etc.) | - 14. | Race - Ame Black, White | | |
| Baltimore, Maryland 21215-0036 | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show disal Eventing in ust be notified at | þ | 1 □ Never Mar 3 🕅 Widowed | ried 2 Marri | ed 1 ∐Yes If Yes, 0 Year or | 2 🔼 No Rive Dates: | | 1 □ Yes | | Specify | | | | ecny. | White | |
| 15- | n 72 hours "natural", vuical Ex | olete | | | s Education t grade completed | ") | 16a. Dec | edent's Usu e <i>kind of wo</i> DO NOT u | al Occup ork done o se retired | ation <i>furing</i> mos n | st of worki | ng | 16b. Kind | of Business/ | Industry | |
| 212 | s within 7 giene. r than "n | Completed | Elementary/Sec 8th | ondary (0-12) | College | (1-4or 5+) | | omemal | | , | | | | Home | | |
| pu | be filed vital Hygid of other event, I | Be C | 17. Father's Name | (First, Middle, L | .ast) | | | | | 18. Moth | er's Name | (First, Middle, | Maiden Su | rname) | | |
| <u>y</u> la | id 2 should be fi Ith and Mental H 27 is marked ot r traumatic even | 2 | Paul Co | | | | | | | | enica | | | | | |
| Mar | S is is | | 19a. Informant's N | | | DIMD | T | | | | | al Route Numb | | | | |
| <u>6</u> | : 1 and 2 ! Health tem 27 i | | Amelia 20a. Method of Dis | M. Cic | c1a . | DTR. | b. Place of Disc | 1 Trea | me of | 1 | | ttingha Date | | Z1Z3 tion - City or | | |
| OE I | Pages ent of nt: If i | | | ☐ Cremation 5 ☐ Other (Sp | 3 Removal from | n State | cemetery, ch lost Ho | | | | -5-20 | 008 | 1 | Nottin | gham | |
| alti | permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. | | 21. Signature of F | | | | | 22. Name a | nd Addre | ss of Facil | ity (| Schimun | ek Fui | neral | Home | |
| 8 | 8 9 E 8 9 | 0 0 | 1 | ano | ono | | | | _ | | d. No | ottingh | am, Mo | | 36 | |
| | | | | art failure. List o | complications that only one cause on | caused the deach line. | eath. Do not e | nter the mo | de of dyir | ig, such a | s cardiac o | or respiratory a | rrest, | | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | Immediate Cause disease or conditi resulting in death | on . | - | | E HEAR | [FAII | URE | | | | | | | |
| 9 | Examiner | | | | Due to | o (or as a cons | sequence of): | | | | | | | | | |
| | 773 | ner | Sequentially list or if any, leading to in cause. Enter Und Cause (Disease o | onditions, nmediate | b. Due to | o (or as a cons | sequence of): | | | | | | | | | |
| V | ecuted ind transit | Examiner | mat miliated even | S | c | | | | | | | | | | | |
| 60, | icate be executed physician and the burial-transit | | resulting in death) | Last | Due to | o (or as a cons | sequence of): | | | | | | | | | |
| Box 68760, | ficate physis the | edica | | | d | | | | | | | - | | | | |
| ×o | eath certific attending p for use as | M/U | IF FEMALE: 23b. Was decede | | 23c. If yes, o | utcome of pre | | □ Catania | | | | | 230 | d. Date of de | livery | |
| D. B | Attending Physician: The law requires that the death certificate be executed r death. sctor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/Medical | in the past 1: 1 ☐ Yes 2 9 ☐ Unknow | X No | | egnant at time | | B ☐ Ectopic ☐ Other (s | | У | | | | Month | nth Day Year | |
| P.O. | that the | | Part II. Other sign | | ns contributing to | death but not | resulting in the | underlying | cause giv | en in Part | 1. | 23e, Did | tobacco use | contribute t | o the cause of death? | |
| rds, | quires than signed I | d by | | | | | | | | | | 1 🗆 | Yes 2□ | No 3□P | robably 4X Unknown | |
| Division of Vital Record | aw requir as been si 2 should I | Completed | | | | | | | | | | 24a. Was | | 24b. Were a | utopsy findings available completion of cause of | |
| Ä | The law cate has page 2 s | Com | | | | | | | | | | auto perfo | ormed? | death? | s 2 No | |
| /ita | ician: The certificate ector, pag | Be (| 25. Was case references: | erred to medical | IIitali | | | | | | *** | h (Check only | one) | | | |
| of | Physic ruthis cral dire | -T | 1 ☐ Yes 2 ☐ 27, Manner of Dea | No ath | | | ER/Outpat 28b. Time | | | 4 🗆 1 | lursing Ho | ome 5 Res | | | ecify) HOSPICE | |
| O | ding f th. After funer | tion | 1 X Natural 2 ☐ Accident | 5 Pending | | te of Injury onth, Day, Yea | r) Injury | | 28c. Injur Wor 1 🗆 | k? Yes 2[|]No | Zou. Describe | now injury t | occurred | | |
| Visi | | ifica | 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could r determ | not be 28e. Pla | ce of Injury - A | At home, farm, | street, facto | | | | 28f. Location | Street and whom state) | Number or F | lural Route Number, | |
| Ö | spital or ours afte neral Dir filled in | Certification: To | 4 🗀 Hollicide | | , but | lding, etc. (Sp | еспу) | | | | | City of 10 | wii, State) | | | |
| | Ho Fur Tely | Medical | 29a. Certifier (Check only one) | 1 X Certifyin 2 Medical | g Physician: To t Examiner: On the and ma | he best of my basis of exar anner stated. | knowledge, de mination and/or | ath occurre investigation | d at the ti | me, date a | and place, eath occur | and due to the red at the time | e cause(s) a , date and p | ind manner a place, and du | as stated. e to the cause(s) | |
| | To the within 2 To the complet | Me | 29b. Signature an | title of certifie | | | | 29 | c Licens | e number | | | 29d. Date | signed (Mon | th, Day, Year) | |
| | / | | | / | M 1- | | | | D | 43 | 725 | | 9 | 131 | 08 | |
| | 6 | | 30. Name and add | iress of person | who completed ca | use of death | (Item 23a) (Typ | e, Print) | | | | | | | | |
| | ·) | to. | DR. TAI | RIQ MAH | | 00 DULA Registrar's S | NEY VA | LLEY | D | TIMO | NIUM, | MD 210 | 093 | | | |
| | Sta Registi | | | FP 0 5 2 | | | - 1111 A | well. | | | | | | | | |
| DH | IMH 17 Rev 1/2 | 2001 | - 5 | EL AD | UUU (A) | Ziple & | J. A. | | | | | | | - | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2008

2. Date of Death

Month
Day
9-2-2008

28514

3. Time of Death

5:05P

| | | | For State Registrar | State of Maryla | • | artment of H <i>rtificate of L</i> | | | iene 19. No. 200 | 8 28516 |
|---------------------|---|----------------|---|--|------------------------------------|---|--|--|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | | 3. Time of Death |
| · Sale | /Medic | al | Sharon 4a. Facility Name (If not institution, give stre | Ann | Main | 4b. City, Town, or | Location of Dooth | August | 31, 2008 | 8:00 A ^M |
| | Examir | er | Franklin Square | | | Rossv | | | , | ore Co. |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 M | 7. Age (In yrs | s. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Feb. 15 | Year) 9. B | irthplace (State or Foreign Country) aryland |
| | 70 | | Usual Residence of Decedent 10a. State 10b. County | | City, Town or Loc | | | 100. 10 | 71545 110 | |
| | Maryla f shov | ō | Maryland Balti | | nty, 10wii or Loc | | le River | | | 10d. Inside City Limits 1 ☐ Yes 2€No |
| | n the h | Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of What 0 | Country? |
| | ath wit | | 3614 Dahlia Lane | | | | L220 | | United St | ates |
| 920 | be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Modicel Ever it at must be notified at | by Funeral | 1 ☐ Never Married 2 ☐ Married | Was Decedent Ever in I Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: | | Vas Decedent of His fYes, specify Cubar □Yes 2 ☑No | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - An Black, Wh Specify: | nerican Indian, ite, etc. White |
| Maryland 21215-0036 | n 72 ho "natura volice Li | Completed | 15. Decedent's Educati (Specify only highest grade co | on ompleted) | (Give | lent's Usual Occupa kind of work done d OO NOT use retired) | uring most of work | ing 1 | 6b. Kind of Busines | |
| 212 | filed within Hygiene. other than " | Somp | Elementary/Secondary (0-12) 12 Years | College (1-4or 5+) | 1 | ookkeeper | | | Account | ing |
| and | be filed v ntal Hygie ed other i | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam Susan | e (First, Middle, M | laiden Surname) | |
| aryla | 2 should be to and Mental is marked or aumatic eve | 은 | Donald Cross 19a. Informant's Name/Relationship (Type. | Print) | 19b. Mailin | o Address (Street a | | | City or Town, State | Zin Code) |
| , M | and 2 ealth a n 27 is | 13 | | rother) | | | | | ore, Mary | |
| Baltimore, | permit. Pages 1 and 2 should bu Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic e once. | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Rem | oval from State | | natory or other place |) ; | | 20c. Location - City of | or Town, State Maryland |
| altin | mit. Pa partme portant / Injury | | 4 □ Denation S □ Other (Specify) 21. Synature | C HIX | /- | ervice Co | | | Dundalk, | - |
| Ä | permi Depa Impo any Ir | 1 | hallote | my | | 7922 Wise | Ave. D | undalk, | Maryland | 21222 |
| J. | Physician /Medical | | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of limmediate Cause (Final disease or condition resulting in death) | ause on each line/ | sclero | fic Cand | _ | (| | Approximate Interval Between Onset and Death |
| | Examiner | Ļ | Sequentially list conditions, b. | | | | | | | |
| | uted d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conse | quence of). | | | | | 1 |
| 30, | tificate be executed g physician and as the burial-transit | I Exa | resulting in death) Last | Due to (or as a conse | quence of): | | | | | |
| 68760, | ficate t physic s the b | edical | d | | | | | | | |
| O. Box | eath cer attendir for use | Physician/M | in the past 12 months? | If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown | aldeath 3 | Ectopic pregnancy | | | 23d. Date of d Month | lelivery Day Year |
| ٠ <u>,</u> | res that the de signed by the be detached | by Ph | Part II. Other significant conditions contrib | uting to death but not re | sulting in the un | derlying cause give | n in Part I. | 23e. Did toba | acco use contribute | to the cause of death? |
| ords | w requires been sig should be | ted b | | | | | | 1 ☐ Yes | s 2 🗆 No 3 🗔 | Probably 4 Unknown |
| Vital Records, | ician: The law r certificate has bo ector, page 2 sh | Completed | | | | | | 24a. Was an autopsy perform 1 □ Yes 2 | prior to | |
| Zi. | ysician: is certific director, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 □ No | oital: 1 ☐ Inpatient 2 | ER/Outpatient | Oab | ,. | n (Check only one | nce 6 □Other (Sp | |
| n o | ding Phys h. After this funeral di | on: To | _ | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury Works | at | 28d. Describe how | | ecity) |
| Division of | I or Attendi after death. Director: A d in by the fu | icati | 2 Accident investigation 3 Suicide 6 Could not be | 8e. Place of Injury - At h | ome farm etre | | es 2□No | 20f Longtion (Ct. | | B / B / M / |
| .≥ | or / or / or / or or / | Certification: | 4 ☐ Homicide determined | building, etc. (Spec | ify) | et, lactory, office | | City or Town, | State) | Rural Route Number, |
| 3 | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical | 29a. Certifier (Check only one) | an: To the best of my kn On the basis of examin and manner stated. | owledge, death ation and/or inv | occurred at the tim estigation, in my op | e, date and place, inion, death occur | and due to the ca red at the time, da | use(s) and manner te and place, and d | as stated. ue to the cause(s) |
| | To the within To the compl | Me | 29b. Signature and title of certifier | > | 1 | 29c. License | number | 29 | d. Date signed (Moi | nth, Day, Year) |
| | 1 | | Lestyfficted IMC | Depu | 14. | | 667 | S | plember | 2,2008 |
| | ') | | 30. Name and address of person who complete the complete | eted cause of death (Ite | m 23a) (Type, F | e. 4:(1 C | Luther | 1:1/2 M | 9 5109 | |
| | Stat Registra | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | ature | books | | | | _ |

08-06687

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2008 285

State of Maryland / Department of Health and Mental Hygiene Sean McGuffie Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day August 31, 2008 Physician/ 2206 hrs **!** Examiner SEAN EUGENE MCGUFFIE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days Director 1 XM 12 Germany 2 F 27 056-74-5608 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 XNo Maryland Harford Edgewood Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21040 125 Redbud Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married Married Yes 2 X No White Yes 2 X No specify: If Yes, Give Year "natural", (| Examiner 1 Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 721
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "n
injury or other traumatic event the Market." 21215-0036 Information System Computer Programmer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Lan Choi James (nmn) McGuffie (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Maryland 21040 Edgewood. James McGuffie / Father 125 Redbud Road, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) Cremation 3 Removal from State 9-5-08 Aberdeen, Maryland Harford Memorial Gdn Donation 5 Other Specify 22. Name and Address of Facility McComas Funeral Home, P.A. mature of Fun 21009 Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and nysician failure. List only one cause on each line. Death Medical Narcotic (methadone, oxycodone) intoxication Immediate Cause (Final disease ∉xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last tending physician and use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and AMENDED 23a,2/,28a-1, perME, g883 9/30/08 TT Physician/Medical X UNPENDED 23d. Date of delivery P.O. Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE. 3 Ectopic pregnancy Day Year Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown 至 Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be Other examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Residence 6 Nursing Home 5 DDA 1 ✓ Yes 2 No 28a. Date of Injury (Month, Day,Year) 28d, Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death unk Yes 2 X No Natural Pending Fnd 8/31/08 Fnd 9:00 filled in by the Certificat 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1 25 Red Bud Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide house Edgewood, determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 2, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Rafistrar's Signature 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

2008

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death -31 **Physician** Virginia Arneta Miller 800. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner SNO 8. Date of Birth (Month, Day, Y. NOV 10, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 92 Yrs. 9. Birthplace **Funeral** Year 1915 Virginia Days 1 □ M 2 🕱 F 149-09-8722 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "hatural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 719 Maiden Choice Lane, Brookside 341 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □Yes 2KNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ¥No White Specify: Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ritner Herbert. Wertley Myrtle 2 R. Meredith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ann Ciotola (Daughter) 4 Bateau Landing, Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) @ loudon Park Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical **Examiner**

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of)

3 Ectopic pregnancy

5 ☐ Other (specify)

Physician/Medical by Completed Be 2 Certification:

| 9 LI OTIKITOWIT | |
|--------------------------------------|---|
| Part II. Other significant condition | ns contributing to death but not resulting in the underlying cause given in Par |
| | |

9□Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death

| resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |
|--|---|
| | 1 Yes 2 No 3 Probably 4 Unknow |
| | 24a. Was an autopsy findings availab prior to completion of cause of death? |

| | | | ILITES ZIENO |
|---|--|--|---|
| 25. Was case referred to medical examiner? | | 26. Place of Dea | th (Check only one) |
| 1 Yes 2 1 H | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient | 3□ DOA Other: 4 Nursing H | ome 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | 28c. Injury at Work? M 1 □ Yes 2 □ No | 28d. Describe how injury occurred |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injury - At home, farm, stree building, etc. (Specify) | t, factory, office | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | | | |

| 29a. Certifier (Check only one) | 1 Certifying Physic 2 Medical Examine | cian: To the best of my knowledge, death or er: On the basis of examination and/or inves and manner stated. | curred at the time, date and place, a tigation, in my opinion, death occurre | and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause |
|---------------------------------------|--|---|--|---|
| 29b. Signature and | title of certifier | | 29c. License number | 29d. Date signed (Month, Day, Year) |
| 1 | o of the | M | D47009 | Santambara |

| , ho | Ì | 2 stars | V | 112 | ĺ |
|------------------|---|--------------------------|--------|----------------------------------|---|
| Name and address | X | person who completed cau | ise of | f death (Item 23a) (Type, Print) | |

23d. Date of delivery

Day

Year

Month

June or geath (Item 23a) (Type, Print)

7// Maiden Choice Lane, Baltimore, MD 21228

32 Registrar's Signature 31. Date filed (Month, Pay, Year)

State Registrar

Medical

| 08-06664 | | | | | | |
|-----------|------|--|--|--|--|--|
| Andre Mai | rtel | | | | | |

| dre Martel | 1 | State of Maryland / Department of Health and Mental Hy -For State Certificate of Death | | 20 | 08 28519 |
|---|----------------|---|---------------------------------|--|---|
| Physicia | | egistrar | 2. Date of Death Month | av Year | 3. Time of Death |
| edical Exami | | Andre Martel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death | August 31, 2 | 4c. County of Deal | 0941 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death westbound Route 50 and Route 197 Bowie | | Prince Georg | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. | 8Date of Birth | | irthplace (State or Foreign ountry) |
| Director | | 250.452.059 1 M 2 F 48 Yrs. Months Days Hours Min. | 2.6 | .60 (| anada |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| <u> </u> | ١ | Trois-Rivieres Provi | nce of | Quebec | 1 Yes 2 No |
| Maryla: 28a-f: d at on | Director | 10e. Street and Number | 109 | . Citizen of What Co | untry? |
| vith the Maryland s 23a or 28a-f show s e notified at once. | | 24 Kochetor+ #3 G80 7J5 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp | pocify Ves or No. | Canao | erican Indian, Black, |
| eath wi | Funeral | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto | | White, etc. | f. |
| after dal", or | P, Y | 3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: | | | naclian |
| hours natur | | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired to the during most of working life. DO NOT use retired to the during most of working life. | vork done 1 red) | 1 ruck | s/Industry |
| 36 thin 72 than ' | Completed | Secondary 5 Trucker | | Comp | sany |
| 5-0036 iled within 7 Hygiene. I other than | | 17. Father's Name (First, Middle, Last) 18.Mother's Name | (First, Middle, Ma | aiden Syrname) | ***** |
| D 21215-003 should be filed within and Mental Hygiene 7 is marked other that is marked other than its | o Be | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address, (Street and Number or F | Rural Route Numb | er, City or Town, Sta | ate, Zip Code) |
| nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene II. If them 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once | Ě | Edith Martel (sister) 1735, 7th Avenue #2 | Montre | al PQ+ | t18452 |
| Ψ - = - L | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City | or Town, State |
| | | 4 Departion 5 Other Specify: Attred Valking Crematory 1. | 10.08 | Laval, Ga | rebec Conada |
| Baltir permit. I Departm Importa injury o | | 21. San tue of Funeral Service Licerty e 22. Name and Address of 15 ity | Tuncal | Home 1 | MD 212K |
| Physician | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac of | or respiratory arres | | Approximate Interval Between Onset and |
| /Medical Examiner | i Y | féilure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Blunt Force Injuries | | | Death |
| ,xammor | | or condition resulting in death) Due to (or as a consequence of): | | | |
| | ner | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | |
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| ecured and transi | | d | | | |
| D, be es' sician | edical | UNPENDED AMENDED | | 23d. Date of deliv | verv |
| Vital Records, P.O. Box 6876(hystrian: The law requires that the death certificate this certificate has been signed by the attending physidirector, page 2 should be detached for use as the b | sician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy | ancy | Month | Day Year |
| ox 6 eath ce attend for use | sici | 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown | | | 1 |
| O. B at the d I by the tached | , Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | to the cause of death? |
| of Vital Records, P.O. ng Physician: The law requires that th Ner this certificate has been signed by neral director, page 2 should be detach | d by | | | | Probably 4 Unknown |
| ords w requas beer | Completed | | 24a. Was a autops perfor | y prior | autopsy findings available to completion of cause of |
| | Com | | 1 ✓ Yes 2 | | |
| ital sician: s certif | å | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing | | Residence 6 V O | ther: Scene |
| n of Vital ding Physician: h. After this certif: | ۲. اع | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? | 28d. Describe h | ow injury occurred | |
| ion tendin leath. tor: A | Certification: | 1 Natural 5 Pending Aug 31, 2008 0920 hrs 1 Yes 2 No | | fixed object coll | |
| Division In or Attending after death. Al Director: / led in by the fi | tific | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. | 28f. Location (S or Town, St | treet and Number or ate) / Route 197 , Bov | Rural Route Number, City |
| Division of N To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th | | 29a. Certifier a Coult in Physician To the heat of my knowledge death occurred at the time date and place and | 1 | | |
| o the H ithin 24 o the F implete | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | at the time, date a | and place, and due to | o the cause(s) |
| E 2 E 2 8 | Me | 29b. Signature and title of certifier 29c. License number | | 29d. Date signed (| |
| | | Mell ay M) O.C.M.E. | | September 1, | 2008 |
|) | í | 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N | MD 21201 | | 1 |
| | tate | 31. Date filed (Month, Day, Year) 32/Registrar's Signature | | | |
| Regis | | SEP 0 5 2008 Magne A position | | 3300 | |

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|--|----------------|--|--|------------------------|--------------------------------|---|
| Physicia | | 1. Decedent's Name (First, Middle,Last) | | 2. Date of Death | . No. | 3. Time of Death |
| edical Exami | ner | John Edgar Magee | | Month I August 31, | Day Year 2008 | 1100 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 3543 5th Street | 4b. City, Town, or Location of Dea Brooklyn | ath | 4c. County of Death |) |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24H | Irs. 8. Date of Birth | (MM/DD/YYYY) 9. Bir | thplace (State or |
| Director | | 213-36-3752 X _{M 2} _F 69 _Y | | Apr 1, | Foreig | |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc | ation | | | 10d. Inside City Limits |
| * | _ | MD Baltimore | | | | 1 X Yes 2 No |
| Maryland 28a-f show 1 at once. | Director | 10e. Street and Number | 10f. Zip Code | 100 | . Citizen of What Cou | ntry? |
| th the Maryland 23a or 28a-f sho notified at once. | Öİ | 3543 5th Street | 21225 | US | SA | |
| h with | eral | 11. Mantal Status 12. Was Decedent Ever in U.S. 13. V | Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer | | 14. Race - Amer White, etc. | ican Indian, Black, |
| or ite | Funeral | 1 A Yes 2 No | | to radan, etal, | | |
| rs afte | ģ | or Dates: | Yes 2X No specify: ent's Usual Occupation (Give kind of | of work done | Specify: Whi | |
| 72 hou | Completed | | most of working life. DO NOT use r | | | |
| 21215-0036 uld be filed within 72 hot Mental Hygiene. marked other than "nat c event, the Medical Exa | ld m | 10 Contr | actor | | Constructi | Lon |
| 15-0 iled w Hygic the h | | 17. Father's Name (First, Middle, Last) | | me (First, Middle, Ma | aiden Surriame) | |
| 2121 uld be fil Mental B marked | Be | | unk) ing Address (Street and Number o | | 0.4 | (unk) |
| 2 D 2 E | ျှ | | 5 5th Street Balt | | | e, Zip Gode) |
| and lealt tran | | 20a. Method of Disposition 20b. Place of Disp | osition (Name of cemetery, | | 20c. Location - City or | Town, State |
| More Pages Int: If i | | 1 Burial 2 X Cremation 3 Removal from State crematory or | ke Crematory 09 | 3/0/1/08 | Relterille | a MD |
| Baltimore, permit. Pages l ar Department of Her Important: If ite | | | Oling of Cremat | | | |
| E.E.Q.E.CO | | they I Keyett MO1251 B | everly L. Heckro | otte, P.A. | . Clarksvi | |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. | r the mode of dying, such as cardia | c or respiratory arres | st, shock, or heart | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | isease | | | Death |
| | | bacto (or as a consequence or). | | | | |
| | ner | if any, leading to immediate Due to (or as a consequence of): | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of): | | | | <u> </u> |
| ecuted and transit | | dd. | | | | |
| a a ex | Medical | UNPENDED AMENDED | | | | |
| 760, ficate be g physici the buri | | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the | | | 23d. Date of deliver | • |
| Box 687 e death certific the attending 1 | sician/ | past 12 months? 4 Pregnant at time of death 5 | Fetal death 3Ectopic preg Other (Specify) | gnancy | Month | Day Year |
| Bo e deat the att | Physi | 1 Yes 2 No 9 Unknown g Unknown | | | <u> </u> | |
| Division of Vital Records, P.O. Box 687 Hospital or Attending Physician: The law requires that the death certific Francral Director: After this certificate has been signed by the attending pely filled in by the funeral director, page 2 should be detached for use as the | by P | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | | acco use contribute to | the cause of death? |
| ls, P.C quires that en signed | | F | | 24a. Was at | | utopsy findings available |
| of Vital Records, ag Physician: The law require the configurate has been sineral director, page 2 should t | Completed | | | autops perform | y prior to | completion of cause of |
| tal Rectian: The certificate ector, page | Con | | | 1 Yes 2 | | es 2 No |
| ician: s certi | Be | 25. Was case referred to medical examiner? Hospital: Inpution: 2 EP/Quitastic | 26.Place of Death (Che | | 0 | |
| of V ing Phys After thi uneral di | : To | 1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of | | | Residence 6 Other | er: Scene |
| On C anding arth. Ar: Af | tion | Natural 5 Pending | 1 Yes 2 No | | | |
| Division to a trending and or attending and a factor or a feed or | fica | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st | reet, factory, office building, etc. | | | ural Route Number, City |
| Division of pital of pital of pital Division of the pital | Certification: | 4 Homicide determined (Specify) | | or Town, Sta | ate) | |
| e Hos 124 ho e Fun letely | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ | | | | |
| Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: completely filled in by the fu | Medical | one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. | | d at the time, date a | | |
| | 2 | 29b. Signature and title of certifier | 29c. License number O.C.M.E. | | 29d. Date signed (Mo | |
| 7 | | Patrille Tolle is | U.C.IVI.E. | | September 1, 20 | |
| +1 | | Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner | 111 Penn Street, Baltim | ore, MD 21201 | | |
| | tate | 31. Date filed (Month, Day, Year) SEP 0 5 2008 3 Registrar's Signature | all I | | | |
| Regis DHMH 17 Rev 1/2 | _ | SET U 5 ZUU0 ORIGIN | IAI | | | |
| | -01 | ORIGIN | ML. | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| | . iouse type of the machine machine |
|----------------------|--|
| Martin Andrew Needer | State of Maryland / Department of Health and M |
| 1- For State | Cortificate of Death |

2008 28521

| | Registrar | incate of Death | Reg. No. | |
|---|---|--|---|-------|
| Physician/ ledical Examine | MARTIN ANDREW NEEDER | 2. Date of Death Month Day September 3, 2008 3. Time of Death 1930 hrs | | |
| | 4a. Facility Name (if not institution, give street and number) 8500 Cove Road - Anchor Bay Marina | 4b. City, Town, or Location of Dea Dundalk | th 4c. County of Death Baltimore County | • |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. lat 213 ~ 68 ~ 0733 | st birthday) If Under 1 Year If Under 24I- Months Days Hours M Yrs. | Country | reign |
| a) | Usual Residence of Decedent 10a. State 10b. County 10c. City, | Town or Location | 10d. Inside City Lin | mits |
| nd show any | Maryland Baltimore | Baltimore County | 1 Yes 2 X | _ |
| the Maryland a or 28a-f show tified at once. | 10e. Street and Number 26 Fullerton Heights Ave. | 10f. Zip Code 21236 | 10g. Citizen of What Country? | |
| or items 23a - must be notil | 1 | | Specify Yes or No- 14. Race - American Indian, Black, | |
| fter deat | 3 Midowed 4 Divorced III Yes Give Year 4 TO 0 1011 | 1 Yes 2 X No specify: | Specify: White | |
| ours aft atural" x mine | 45 Decided Education (Constitution between accordated) | 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r | | |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ceal hand Mental Hygiers have a state and and Mental Hygiers than "natural", or items 23a or 28a-f she traumatic event, the Medical Ex miner must be notified at once To Re Commissed by Finneral Director | Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs. | Railroad Constructio | | |
| ore, MD 21215-0036 es 1 and 2 should be filed within 72 of Health and Mental Hygiene. If iften 27 is marked other than ther traumatic event, the Medical | 17. Father's Name (First, Middle, Last) George Needer | | ne (First, Middle, Maiden Surname) a Howell | |
| MD 21 nd 2 should thth and Mer m 27 is man aumatic ev | | | r Rural Route Number, City or Town, State, Zip Code) ts Avenue Baltimore, Md. 2L | 236 |
| nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic | 20a. Method of Disposition 20b. P | Place of Disposition (Name of cemetery, rematory or other place) | Date 20c. Location - City or Town, State | |
| imore Pages 1 ment of F tant: If i | | | -8-2008 Baltimore, Md. | |
| Baltimore, permit, Pages 1 at Department of Hee Important: If ite injury or other ir | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. | Home, Inc. Baltimore, Md. 21236 | |
| Physician | 23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. | | | |
| /Medical | Immediate Cause (Final disease a. Drowning | • | Death | 1 |
| | or condition resulting in death) Due to (or as a consequence of |): | | |
| ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c. |): | | |
| uted d ansit | |): | | |
| 58760, rriistate be executed ling physician and e as the burial - transi | UNPENDED AMENDED | | | |
| 6 5 5 8 7 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of deal | 2 Fetal death 3 Ectopic pres | nancy Month Day Year | |
| by the attendiched for use. | 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not re | southing in the underlying source given in Port I | 23e. Did tobacco use contribute to the cause of death | 2 |
| ires that the signed by lee detach | Atherosclerotic Cardiovascular Disease | sutting at the underlying cause given in Furt. | 1 Yes 2 No 3 Probably 4 V Unkno | |
| ords, F | | | 24a. Was an autopsy prior to completion of cause | |
| Records, The law requires freate has been significate has been significate has been significate has been significated for the state of | | | performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No | |
| tal R cian: 1 certific ector, p | 25. Was case referred to medical | 26.Place of Death (Che | ck only one) | |
| of Vital Recting Physician: The After this certificate funeral director, page | 1 V Yes 2 No Inpatient 2 | ER/Outpatient 3 DOA Other; Nur 28b. Time of Injury 28c. Injury at Work? | sing Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred | |
| Division of Vital Records, ital or Attending Physician: The law requir na bien etem: After this certificate has been silted in by the funeral director, page 2 should be attification: To Re Completes | 27. Wallier of beath 1 Natural 5 Pending 1 VAccident Investigation Page 2 Sep 3, 2008 | FOUND: 1922 hrs 1 Yes 2 No | Subject fell from boat into creek | |
| Divisi nital or Atures after durs after di ral Direct | 3 Suicide 6 Could not be determined (Specify) Creek | ome, farm, street, factory, office building, etc. | 28f. Location (Street and Number or Rural Route Number, or Town, State) Bear Creek , Dundalk , MD | City |
| Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for underlies of Completely filled in by the funeral director, page 2 should be detached for underlies of Completely filled in the physician. | | ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurre | nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s) | |
| . E S E S | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) | |
| 7 | 30 Name and address of person who completed cause of death (Item | O.C.M.E. | September 4, 2008 | |
| 15+1 | Laron Locke MD. Assistant Medical Examiner | 111 Penn Street, Baltimore, MD 2 | 1201 | |
| Stat Registra | OFF 0 = 2000 | re | | |
| DHMH 17 Rev 1/2001 | 25 L 0 2 5000 Sugaries 5 | ORIGINAL | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 **Physician** Timothy Todd Neubauer 2008 31 12:00 P^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 417 142nd St. Unit 2 Ocean City Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/24/1960 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 48 218-76-6285 MD Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It am "matural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 417 142nd St. Unit 2 21842 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Completed by 3 ☐ Widowed 4 ♣ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker welder Iron Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Milton Neubauer Mable Todd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Neubauer / daughter 417 142nd St., Unit 2., Ocean City, MD 21842 Department of Health Important: If Item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CINALYRAM SHOUALL ARDENT CREMATORY 9/5/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility ARDENT CREMATIO 50d 7522 CONNEWLY DE. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZYEARS Physician IVER CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes MASS 2 No 2 No 5. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 ☐ Homicide

↑ DVC(- 10 WE Division or Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: completely filled in by the f

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title

6lenni

31. Date filed (Month, Day, Year)

9714 Healthway

and manner stated.

ss of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28523 State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 2, 2008 ALPHA DORIS HALL NICHOLSON 7:40 A /Medical 4c. County of Dealh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Woods Center Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2√2 F Dec. 18, 1922 <u> 230–16–7466</u> 85 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Completed by Funeral Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 136 E. Pennsylvania Ave. 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ₩Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Connor Buren Hall Nannie Abigail Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Thomas Point Court, Parkville, ND 21234 Bradford W. Nicholson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-6-08 Bel Air, Maryland Bel Air Memorial Gdn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MCCOmas Fineral Home

Physician /Medical Examiner

Depertment of H Important: If Its any Injury or of 2058.

permit.

Funeral

Director

worde !

Pages 1 end 2 should be filed within 72 hours after death with the Maryla ment of Heelth and Mental Hygiene.
ant: If Item 27 Is marked other than "naturel", or Items 23a or 28s-1 show ury or other treumatic event, Ira Modical Examinar must be notified at

Baltimore, Maryland 21215-0036

with the Maryland

To the Hospital or Attending Physicien: The law requires thet the death certificate be executed attending pl sign d be s certificate has I lirector, page 2 s within 24 hours efter death
To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

| | Steple a 1/0 | Lieply | 1317 | Cokesbury Roa | ad, Abingdo | n, Maryl | and 21009 |
|----------------------------|--|--|------------------------------------|---|--|---------------------------------------|--|
| 1 | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | lications that caused the death. Do not no cause on each line. | | | | , | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulling in dealh) | a ATherosche | POTI | c HEAR | r QISC | ease | Onset and Death |
| Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last | Due to (or as a consequence of) | 1510 | | | | |
| /Wed | IF FEMALE: | 23c. If yes, outcome of pregnancy | | | | 23d. Date of de | livon |
| ysician | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | 3 ☐ Ectopic p 5 ☐ Other (s | | | Month | Day Year |
| | Part II. Dther significant conditions co | ntributing to death but not resulling in It | ne underlying | cause given in Part I. | 23e. Did tobacc | use contribute to | o the cause of death? |
| ed p | CHF, MULTIP | Le Decubit | i D | ialetes | 1 ☐ Yes | 2. No 3 □ P | robably 4 🗆 Unknown |
| Completed by | DVT RIGHT | Log | | | 24a. Was an autopsy performed 1 Yes 2 | prior to death? | utopsy findings available completion of cause of |
| Be | 25. Was case referred to medical examiner? | | | | ath (Check only one) | | |
| ٥ | 1 □ Yes 2 No | Hospital: 1 ☐ Inpalient 2 ☐ ER/Outp | atient 3 D | OA Other: 4 Nursing H | lome 5 Residence | 6 ☐Other (Spe | ecify) |
| atlon; | 27. Manner of Death Natural 5 Pending 2 Accident investigation | 28a. Date of Injury 28b. Tin (Month, Day Year) Inju | ne of Iry M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in | jury occurred | |
| Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - Al home, farm building, etc. (Specify) | , street, factor | ry, office | 28f. Location (Street City or Town, St. | | ural Route Number, |
| edical | 29a. Certifier (Check only one) 2 Medical Exam | rsician: To the best of my knowledge, of iner: On the basis of examination and/of and manner stated. | death occurred or investigation | d at the time, date and place n, in my opinion, death occu | e, and due to the cause urred at the time, date a | (s) and manner a and place, and du | s stated. e to the cause(s) |
| Σ | 29b. Signature and title of certifier | 0 | 29 | c. License number | | Date signed (Mon. | th, Day, Year) |
| | //. | 1-11 | 1 | 111 | | 1 | |

State Registrar

31. Date filed (Month, Day, Year) SEP 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 09:00 PM Nilsson 2008 Doris S. August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville Brightview Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Sept. 10 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Min. Days Hours Months 1 M 2 F Sept. 95 1912 **Director** 056-03-4081 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Myclical Exprimer is use be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 912 S. Rolling Road 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White ⋛ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 12 Bell Telephone s 1 and 2 should be filed with Health and Mental Hygier Item 27 is marked other them 27 is marked other them 15 is marked other 15 is marked in 15 is marke 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Richard Behrens Agnes Magnuson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trans Daryl Rohrbacher Hidden Bluff Circle, Catonsville, MD 21228 20c. Location - City or Town, State 20a. Method of Disposition Sept. Date 02 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Sleepy Hollow Cemetery Sleepy Hollow, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Ap Ba burial-trar Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: nse n 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by the a 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → O 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 □ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASURO Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Year) 1 atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, The Hospital or Attending Physician: n 24 hours after death.

Be Funeral Director: A pletely filled in by the fu death. completely the the within 7

Baltimore, Maryland 21215-0036

3 Suicide Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

31. Date filed (Month, Day,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

480 32. Registrar's Signatur

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 24 aro 00 28 AM Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death & Rehab Baltimore Heinst Iteal1h If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Navy Hours | Min. | (Month, Day, Year) 6. Sex Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 M 2 Y 7,1961 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Nes 2 No IMOTR Oi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 othian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) actori Manutac 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Butler-Rd Lothian Balto. Mother MD 5411 Shirle 21212 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 □ Removal from State Kandallsteum 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL Funeral Balte. 4600 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Hyman Perency disease or condition resulting in death) 1mm4nDue to (or as a consequence of): lears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse rto (br as a co IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 2X No 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

physician and is the burial-trans as attending for use as ed by the a signed t peen ate has t

Physician/Medical

P.O. Box 68760,

Records,

Division or Vital

The law requires that the death certificate be executed certificate | To the Hospital or Attending Physician: funeral director this After t after death To the Funeral Director: completely filled in by the 24 hours

State

Completed 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29b. Signature and title of certifier Itmater Ul Macen MD

29d. Date signed (Month, Day, Year)

Name and address of person who comprehen and address of person who comprehen and address of person who comprehen a supplied to the supplied of the supplied to 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in Street Baltimore

31. Date filed (Month, Day, Registrar

08-06630 John Andeau Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Common Control Control C | TO CORDEN STORY OF THE STATE OF | Andeau | F | egistrar | epartment of Certificate of a | Death | Reg. No. | 2008 2852 |
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| Second Secondary Number Color Secondary Color Co | Social Security Number: 2 13 - 58 - 3375 No. 10 cm. 1 | | | a. Facility Name (if not institution, give street and number) | | c. City, Town, or Location of Death | 4c. Coun | |
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| 29b. Signature and title of certifier O.C.M.E. August 30, 2008 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | 29b. Signature and title of certifier 29c. License number O.C.M.E. August 30, 2008 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Segistrar's Signature | thin 24 hosp thin 24 hosp the Funer mpletely fir | | 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my know) | nowledge, death occur | red at the time, date and place, and tion, in my opinion, death occurred | d due to the cause(s) and ma | anner as stated. |
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| | | | For State Registrar | State of Maryla | and / Dep <i>Ce</i> | artment of He rtificate of De | ealth and M | ental Hygi | iene _{eg. No.} 200 | 0. 08 28527 |
|---------------------|---|-------------------|---|--|-------------------------------------|--|---|---|------------------------------------|---|
| | Physici /Medi | | Decedent's Name (First, Middle Charles | Nicholas | Podol | ak Sr. | | 2. Date of Death Month Septemb | Day Ye | aar 3. Time of Death 1:05 A M |
| | Examir | | 4a. Facility Name (If not institution 734 Franz | | | 4b. City, Town, or Lo | | 201204.10 | 4c. County of Harfor | Death |
| | Funeral Director | | 5. Social Security Number 196-09-6318 | | rs. last birthday) 2 Yrs. | If Under 1 Year | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Jan. 27 | Year) 9. | Birthplace (State or Foreign Country) Pennsylvania |
| | Maryland a-f show | tor | Usual Residence of Decedent 10a. State 10b. County Maryland Har | | City, Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🕱 No |
| | h with the 23a or 28a st be noti | al Directo | 10e. Street and Number 734 Franz Driv | | ADIII GUOI | 10f. Zip Code 21009 | | 10 | og. Citizen of Wha | at Country? |
| 36 | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examirer must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? | | Was Decedent of Hisp If Yes, specify Cuban, | panic Origin? (Spe Mexican, Puerto F Specify: | cify Yes or No- Rican, etc.) | 14. Race - | American Indian, White, etc. |
| Maryland 21215-0036 | ithin 72 hou ne. nan "natura IMedical E | Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | 's Education | (Give | dent's Usual Occupation kind of work done during the properties of the proper | on ring most of workin | | 16b. Kind of Busin | ess/Industry |
| and 21 | e d la B | Be | 17. Father's Name (First, Middle, L | ast) | Iro | n Worker | 8. Mother's Name | (First, Middle, M | faiden Surname) | al Building |
| Maryla | | ဥ | John (nmn) Pod 19a. Informant's Name/Relationsh | ip (Type. Print) | | ng Address (Street and | d Number or Rural | Route Number, | | |
| ď. | Pages 1 and 2 nent of Health int: If item 27 i iry or other tra | | Charles Podolak 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp | 20b 3 □ Removal from State | o. Place of Dispo cemetery, crei | Franz Driv | Da | ate 2 | 20c. Location - Cit | |
| Balti | permit. Pages Department of Important: If i any Injury or once. | | 21. Signature of Funeral Service L | 7 10, | ²² | v Cemetery 2. Name and Address 2. Occomas Fur 1317 Cokest | neral Hom | e, P.A. | | . Pennsylvania 21009 |
| | Physician /Medical Examiner | | 23a. Part 1. Enter the disease, or shock, or heart-failure. List of Immediate Cause (Final disease or condition resulting in death) | complications that caused the de | th. Do not ent | | | | | Approximate Interval Between Onset and Death |
| | | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last | b | | | | | | |
| Box 68/60 | within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | d | etal death 3 | Ectopic pregnancy | | | 23d. Date o | |
| л О | ed by the detached | | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition | 4 ☐ Pregnant at time o 9 ☐ Unknown | | Other (specify) | in Part 1 | 23e. Did tob | | ite to the cause of death? |
| cords, | been sign should be | Completed by | ardionyopo | itny Hype | v tensio | n atrio | 11 fib | 1 ☐ Yes | s 2 No 3[| ☐ Probably 4☐ Unknown |
| vital Records, | rtificate has tor, page 2 | Be Comp | 25. Was case referred to medical | 5 ynavsine | | 26 | 6. Place of Death | | prio dea | e autopsy findings available r to completion of cause of th? Yes 2 □ No |
| > 10 | r this ce ral direc | <u>۵</u> | examiner? 1 Yes 2 No 27 Manger of Death | Hospital: 1 Inpatient 2 28a. Date of Injury | ER/Outpatier | t 3 DOA Other: | 4 ☐ Nursing Hom | e Resider | nce 6 Other | (Specify) |
| VISION OF | ar death. ector: Afte by the fune | Certification: | Natural 5 Pending investige 3 Suicide 6 Could not determin | (Month, Day, Year) | Injury | M 1 ☐ Yes | s 2 No | 3f. Location (Stre | w injury occurred eet and Number o | or Rural Route Number, |
| U Island | t hours after uneral Director | | 29a. Certifier 1 Certifying | Physician: To the best of my ki xaminer: On the basis of examiner | nowledge, death | occurred at the time. | date and place, a | nd due to the ca | use(s) and mann | er as stated. |
| Tother | within 24 | Medical | 29b. Signature and title of certifier | and manner stated. | Tation and or in | 29c. License nu | | | d. Date signed (M | |
| _ | 5 | | 30. Name and address of person w | ho completed cause of death (Ite | em 23a) (Type, 1 | Print) SCHWY | \$162 E | daewoo | of My | 24040 |
| | Stat Registra | ar | 31. Date filed (Month, Day, Year) SEP 0 5 | 32. Registrar's Sign | nature | Als. | | 1 | | |
| DHM | H 17 Rev 1/20 | 01 | | 1-000 | OR | GINAL | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PTEMBER **Physician** Fred Douglas Parker 2228 04:41A M /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Joseph Medical Center 8. Date of Birth (Month, Day, Year) 02/14/1935 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2□ F Months Days Hours 73 245-42-4850 Director Usual Residence of Decedent 10c. City, Town or Location Towson death with the Maryland 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinational barrothfied at Baltimore Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 USA 500 Virginia Ave. Apt. 1402 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xfes 2 □ No If Yes, Give Year or Dates: 1953 - 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) State of Maryland Courier 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk Parker Hazel Estelle Worslev မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredrick Douglas Parker/Son 500 Virginia Ave. Apt. 1402 Towson, MD21286 item 27 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. Department of Important: If it any injury or conce. |Beltsville, MD Chesapeake Crem. 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili@AFA/Stephen D.Lohrmann P.A. MO144 8**717** Green Pastures Dr. Balt. MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ADULT RESPIRATORY DISTRESS SYNDROME /Medical Due to (or as a consequence of): Examiner PNEUMONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine 3 physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed METASTATIC PROSTATE CANCER resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 **X** No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Monte, Day, Year) 29b. Signature and ti 29c. License number D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 7671 05 32. Registrar's Signature OSLER DRIVE State Registrar DHMH 17 Rev 1/2001

ORIGINAL

| | | _ | For State Registrar | State of | f Marylar | nd / Depa <i>Cei</i> | artmen rtificat | t of H e <i>of L</i> | ealth a Death | and M | ental Hyg | giene Reg. No. | 008 | 28529 |
|-------------|---|------------------|---|--|--|---|----------------------------------|-------------------------|----------------------------------|------------------------|--|-------------------|-----------------------|---|
| 7 | Physicia /Medic | | 1. Decedent's Name (First, Middle, La Wilma O. Reed | ist) | | | | | | , | 2. Date of Dea Month AUGUS | Day | 200 | 3. Time of Death |
| | Examin | | 4a. Facility Name (If not institution, git Franklin Woods | ve street and nun | nber) | | 4b. City, | | Location of | of Death | , , | 4c. (| County of De Balt | |
| | Funeral Director | | | Sex 1□M 2∏F | 7. Age <i>(In yr</i> s. 82 | . last birthday) Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Da 3-5-1 | 9 26 | 9. E | Birthplace (State or Foreign Country) Md • |
| | aryland show | 5 | Usual Residence of Decedent 10a. State 10b. County Md. Harfo | ord | 10c. Ci | ity, Town or Lo Abin | ecation gdon | | | | | | | 10d. Inside City Limits 1 ☐ Yes ⊋☐ No |
| | or 28a-f | Directo | 10e. Street and Number | Davi | | | 10f. Zip | | 1000 | | | - | en of What | |
| | ar death v | Funeral Director | 2000 Knotty Pir | 12. Was Dece | edent Ever in U | J.S. 13. | Was Deced | | 1009 spanic Ori n, Mexicar | gin? (Spe | ecify Yes or No Rican, etc.) | . US | | merican Indian, /hite, etc. |
| 215-0036 | hours afte tural', or i | ρ | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Tes If Yes, Giv Year or Da | 2 No re X ates: | | 1 🗆 Yes | | Specify: | | | | Specify: | White |
| -5121: | should be filed within 72 hours after death with the Maryland and Mental Hygiane. "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, it a Medical Esaminar must be rolling a | Completed | 15. Decedent's Elementary/Secondary (0-12) 8yrs | ade completed) College (1 | -4or 5+) | 16a. Dece (Give life. | kind of wo. DO NOT us Home | rk done d se retired | luring mos) | t of worki | ng | | of Busine | issimuustry |
| Maryland 21 | buld be filed Mental Hygi arked other atic event, I | To Be C | 17. Father's Name (First, Middle, Las Oscar Marshall | t) | | | | | | | (First, Middle, | Maiden : | Sumame) | |
| Mary | S se se | Ε. | 19a. Informant's Name/Relationship David Reed | (Type, Print) | n | | | | and Numbe | er or Rura | Abin | | | |
| a) | m O - 1 | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Operation 5 Other (Spec | ☐Removal from | 20b. | Place of Dispo cemetery, crei Gardens | osition (Nar matory or o | ne of ther plac | e) | | Date | | cation - City | or Town, State |
| Baltir | permit. Page Department Important: If any injury or once. | | 21. Signature of Funeral Socice Lice | | | | 2. Name ar | d Addres | s of Facili | DCI | nimunek | | eral E | Iome |
| | | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final | nplications that c | aused the dea ach line. | | ter the mod | le of dyin | g, such as | cardiac o | | rrest, | | Approximate Interval Between Onset and Death |
| | Pnysician /Medical Examiner | | disease or condition resulting in death) | a. Due u | (or as a conse | | rroe | a Oc | MAE | 2 (| asci | nom | r | 1 |
| 7 | rted r | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to | (or as a conse | quence of): | | | | | | | | |
| 8760, < | s be executed sician and burial-transit | dicai Exa | that initiated events resulting in death) Last | C. Due to | (or as a conse | quence of): | | | | | | | | 3 |
| x 687 | ertificate ling physi e as the b | Medic | IF FEMALE: | d. | | | | | | | | | | |
| O. Box | The law requires that the death certificate be executed te has been signed by tha attending physician and yage 2 should be detached for use as the burial-transit | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | oirth 2 ☐ Fet eant at time of | tal death 3 | ∃Ectopic pi ∃ Other (sp | | <u>.</u> | | | 2 | 3d. Date of Month | delivery Day Year |
| ds, P. | uires that the de signed by tha a id be detached f | by | Part II. Other significant conditions | contributing to de | eath but not re | sulting in the u | inderlying o | ause give | en in Part I | l. | | | | e to the cause of death? Probably 4 □Unknown |
| Records, | ne law require has been sl ge 2 should t | Completed | | | | | | | | | 24a. Was | | 24b. Were prior death | e autopsy findings available to completion of cause of h? |
| | G LT | Be Co | 25. Was case referred to medical | | | | | | 26. Place | of Deat | 1 Yes | 2ENo | 10 | |
| ot < | Physician: r this certificaral director. | 2 | examiner? 1 Yes 2 Death | Hospital: 1 🔲 | | ER/Outpatie | | | 4 | | me 5 Resi | | | Specify) |
| ion | ding h. After fune | ation | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati | (Mon | th, Day Year) | 28b. Time o Injury | M | 28c, Injun Worl | γat <br Yes 2□ | | 28d. Describe | now injury | occurred. | |
| Division of | 0 0 0 | Certification: | 3 Suicide 6 Could not 4 Homicide determine | 289. Place | of Injury - At I ing, etc. (Spec | home, farm, st sify) | reet, factor | y, office | | | 28f. Location (City or To | | | r Rural Route Number, |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | edical | 29a. Certifying F (Check only one) 1 Certifying F 2 Medical Example 1 | Physician: To the aminer: On the b and man | best of my kn asis of examin ner stated. | nowledge, deat nation and/or in | vestigation | , in my o | pinion, dea | nd place, ath occur | and due to the red at the time, | date and | place, and | due to the cause(s) |
| | Veit Vo | Σ | 29b. Signature and title of certified | // | 1 | 1110 | 29 | c. Licens | number | /- | | 1 | 1 - | Ionth, Day, Year) |
| | 10 | | 30. Name and address of person who | completed caus | se of death (Ite | om 23a) (Type, | Print) | \(\sigma\) | 0.10 | 70 | 0 11 | /hg | USTO | 19, 2008 D2/237 |
| | Sta | to | Jon Edmond SUN 31. Date filed (Month, Day, Year) | 9105 | TANKI Registrar's Sign | in Syr | rour & | Do, | Ste. | 5/2, | 13m/t | mos | e, M | 02/23/ |
| | Registr | | SEP 0 5 20 | 108 /6 | Registrar's Sign | 4 de | W. I | | | | | | | |

08-06538 Neal Revie

M£

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 28530

| | | | For State | | | | Cert | ificate of | Death | | | _ | | Reg. No | | | | |
|---|------------------|----------------|--|----------------|----------------------------|----------------------------|--------------------|--|-------------------------|------------------------|-------------------|------------------------|-------------------------------|-------------------------------|-------------------------------|-------------|------------------------------|-----------------------------|
| Physici | | 1. | Registrar 1. Decedent's Name (First, Middle, Last) Neal Patrick Revie 2. Date of Death Month Day Year August 27, 2008 | | | | | | | | | 3. Time of I 0229 h | | | | | | |
| | | 4: | a. Facility Name (i | | - | et and number |) | 4 | b. City, To Norrisv | | ocation of | Death | | 1 | c. County o Harford | f Death | | |
| Funeral | | 5 | Social Security N | umber | 6. Sex | | ge (In yrs. la | st birthday) | If Under | 1 Year Days | If Under Hours | 24Hrs. Min. | 8. Date of E | , | | Foreig | | |
| Director | | _ | 19-35-01 | | 1 X M | 2F | 23 | Yrs. | | | | | 01-2 | 7 <u>-19</u> | 85 | | untry) 1 | 1D |
| ith the Maryland 23a or 28a-f show any notified at once. | | 1 | sual Residence of 0a. State | 10b. County | ford C | County | | Town or Location | | | | _ | | | | | | City Limits 2 X No |
| aryland 8a-f sh at onc | Director | 1 | 0e. Street and Nu | | 1014 | | | | 10f. Zip (| Code | | | | 10g. C | tizen of Wh | at Cou | ntry? | |
| the Ma is or 2 | ءَ ا | | 5067 Nor | risvi | lle Rd | l | | | | 161 | | | | US. | | | | |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene. Intil Titlem 27 is marked other than "natural", or items 23a or 28a-f sht cather fraumatic vent, the Medical Examiner must be notified at once | Funoral | 1 | Mantal Status Never Marrie | | | | | If Yo | S Decedences, specify | Cuban, | Mexican, | n? (Spe Puerto F | cify Yes or I lican, etc.) | No- | 14. Race White Specify: | e, etc. | ican Indian, | ыаск, |
| urs afte tural", | 1 | ⋧┞ | 3 Widowed 15. Decedent's Ed | - | or D | ates: | ompleted) | 16a, Deceden | t's Usual C | ccupatio | on (Give k | ind of wo | ork done | 16b | Kind of Bu | | | |
| nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: Filem 27 is marked other than "natural", other traumatic event, the Medical Examiner | plotola | najaidwon | Elementary/Seco | | | College (1-4 o | | during m Cable | st of work | | DO NOT (| use retire | ed) | | BGE | | | |
| 5-0036 iled within 77 Hygiene. I other than | | 5 | 7. Father's Name | (First, Middl | e, Last) | | | | | 1 | 8.Mother's | s Name (| First, Middle | e, Maide | n Surname |) | | |
| 2121; ould be fill Mental F marked | 1 | e l | Douglas 19a. Informant's Na | | | D.:-A. | | 19b. Mailing | Addross | /Stroot | | | Croud | Jumber | City or Tow | n. Stat | e. Zin Code) | |
| MD 2 rd 2 should lith and M m 27 is m | | 2 7 | Pamela F | | (Moth | | | | | | | | nite H | | | | | |
| e, M l and 2 Health item 2 | | | 20a. Method of Dis | position | | | | Place of Dispos crematory or ot | ition (Nam | | | | Date | 20 | c. Location | - City o | r Town, Stat | е |
| Pages ent of mt: If | o li | - 1 | 1 X Burial 2 4 Donation 5 | | | Removal from S | State | lly Hil | 1 Mer | | | | | | | | iver, | |
| Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Triem 27 is marked other triming or in smarked other triming or other transmatic event, the Medical pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event, the Medical Pages of the standard or other transmatic event. | o ćanfur | 1 | 21. Signature of Fu | meral Servi | D) (See | | • | 970 | 5 Bel | Lair | Rd E | Balt: | imore, | , MD | 2123 | 6 | mes Ir | ıċ |
| Physicia | | 1 | 23a. Part I. Enter t | he disease, | or complicati | ons that cause | ed the death | . Do not enter t | he mode o | f dying, | such as ca | ardiac or | respiratory | arrest, s | shock, or he | eart | Betwee | nate Interva n Onset and |
| Medica _xamine | | | Immediate Cause or condition result | (Final disea | se a. Cor | ntact Shoto | | nd of Head | | | | | | | | | - | Death |
| | | ı | | | b. | to (or as a co | nsequence c | n). | | | | | | | | | | |
| | | | Sequentially list or if any, leading to it cause. Enter Und | mmediate | | to (or as a co | nsequence o | of): | | | | | | | | | | |
| uted / | ansıt | Exam | (Disease or injury events resulting in | that initiated | 1 C. | to (or as a co | nsequence o | of): | | | | | | | | | | |
| e executed | ırıal - tı | dica | UNPENDE |) | _ An | MENDED | | | | | | | | | | | | |
| that the death certificate be executed red by the attending physician and | or use as the bu | | IF FEMALE: 23b. Was deceden past 12 month | is? | the 1 | | at time of d | 2 F | etal death ther (Spe | 3 [| Ectopi | c pregna | ncy | | 23d. Date of Month | of delive | Day | Year |
| P.O. B s that the de gned by the | letached | by Phy | Part II. Other sign | nificant con | | | | resulting in the | underlying | cause g | given in Pa | art I. | | | | | to the cause | _ |
| ords, F w requires s been sign | | Completed | | | | | | | | | | | 24a. V | Vas an autopsy performe | 24b | . Were | autopsy find o completion | ings availab |
| Reco | page 2 | E | | | | | | | | | | | 1 🗸 Y | es 2 | No | 1 🗸 | | 2 No |
| ician: | rector | Be | 25. Was case refe examiner? | | ical Hosp | pital: | atient 2 | ER/Outpatier | | 26.Place | of Death Other | | only one) ng Home 5 | Re | sidence 6 | ✓ Ot | her: Scene | |
| _ = = ~ ; | uneral | on: To | 1 ✓ Yes 27. Manner of De 1 Natural | | ending | 28a. Date of FOUND: | Injury ay,Year) | 28b. Time of FOUND: | | 28c. Inju | ry at Worl | k? | - | ribe how | injury occu elf | irred | | |
| ViSI or Att fler d | ed in by the | Certification: | 2 Accident 3 Suicide | 6 c | ould not be etermined | | of Injury - At | 0229 hrs home, farm, str reation Area | | , office t | building, e | etc. | or Tov | wn. State | | | Rural Route | Number, Ci |
| he Hospit in 24 hour he Funers | | | 4 Homicide 29a. Certifier (Check only one) | Certifying | Physician: Examiner: Or | To the hest o | of my knowle | dge, death occ and/or investig | urred at the | e time, d y opinior | ate and pl | lace, and | due to the at the time, | cause(s | s) and manr d place, and | er as s | tated. the cause(s | \$) |
| To d | com | Medical | 29b. Signature ar | | an | d manner stat | ed | | | | se numbe | | | | | - | Month, Day, | |
| | | | Jon | ha | Me | y nu | 0 | | | O.C. | .M.E. | | | | August 2 | 7, 20 | 08 | |
| 15 | | | 30. Name and ad Tasha Gre | | | pleted cause Sistant Me | | | 1 Penn | Street, | Baltim | ore, M | D 21201 | | | | | |
| | Sta | ate | 31. Date filed (Mo | | | | strar's Signa | The same of the sa | melle | , | | | | | | | • | |

State of Maryland / Department of Health and Mental Hygien) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 **Physician** Kenneth A. Randlett, Sr. /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 01/06/1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 213-34-6492 1MM 2□F 71 MĎ Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County 1 Yes 2 No MD Baltimore Baltimore City Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7510 Moyer Ave. 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces:

1 Nos 2 No
if Yes, Give
Year or Dates: 1954-1950 1 Never Married 2 Marned 1 ☐ Yes 2 No Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Gas and Electric Co Pages 1 and 2 should be filed within the Pages 1 and Mental Hygiene. Meter Wireman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent A. Randlett, Sr. Freida D. Helaine 19a. Informant's Name/Relationship (Type, Print) Self 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7510 Moyer Ave. Balti. MD, 21234 Health a Kenneth A. Randlett Sr./ Ees 20b. Place of Disposition (Name of cemetery, crematory or other place) 30, 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
important: if ite
eny injury or oti Aug. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crem. 2008 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licenses NO1443 Pastures Dr. Balti, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Metastatic Onset and Death Colon Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that included and or injury) Dire to (or as a consequence of): Examiner physicien and s the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 ⊡Unknown 1 Yes 2 No 3 Probebly Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2ENo 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 1 🔲 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of conflict 29c. License number 28, 2008 1)005857 Jena 30. Name and address of person who completed cause of death (Item 23a) (Type 5601 Loch Roxen 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:00 PM_M **Physician** 2008 August 30, Martha Fisher Rogers /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign VA Date of Birth (Month, Day, Year) 10/02/1910 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 🖾 F 97 Months Days 706-07-5511 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar wast be notified at 1 ☐ Yes 2 No Director MD Chevy Chase Montgomery death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 20815-United States 23a 4720 Chevy Chase Dr. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 ō If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. ģ Specify: White 3 ₩ Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked (Unknown) (Unknown) Fisher ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #402 Chevy Chase, MD 20815f Health iftem 27 i Joseph H. Fitzgerald/Son 4720 Chevy Chase Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sep Date Department of Important: If its any Injury or o once. 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Rapp Funeral & Cremation Services M0038Z Silver Spring, Maryland 20910-933 Gist Ave. Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** OK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): amb. law requires that the death certificate be executed Due to (or as a consequence of) the burial attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a Records, P.O. 9 HInknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D6630L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

SUNOY GHOSH

31. Date filed (Month, Day, Year)

TAGORE

SEP 0 5 2008

M.D.

egistrar's Signature

8600 OLD GEORGE TOWN

BETHESDA MD

| | | | For State Registrar | | State of Ma | ryland | | rtment of H <i>tificate of D</i> | | and Men | | ene 2008 | 28533 |
|---|---|----------------|--|-------------------------------|---|----------------|--|---|--------------------------|----------------------------------|------------------------------|--------------------------------------|--|
| | | | | e (First, Middle, Las | st) | | | | | | Date of Death | | 3. Time of Death |
| | Physicia /Medic | | Julio | n Brea | cken R | ouer | | | | A | Month WOUS+ | 29 2005 | x 13:33 M |
| | Examin | | 4a. Facility Name (| | e street and number) | | | 4b. City, Town, or | Location o | of Death | | 4c. County of Dea | |
| d' | | | Howard | | y Genera | | / | Columbi | a | | | Howar | |
| | Funeral | | 5. Social Security N | | ew 7. Age M 2□F | (In yrs. las | t birthday) _ Yrs. | If Under 1 Year Months Days | If Under | Min. | Date of Birth Month, Day, | 'ear) Co | rthplace (State or Foreign ountry) |
| | Director | | 216-20- Usual Residence of | 0-176 | X | 800 | 115. | | | H | youst, a | 21,1926 | MD |
| | yland now | | 10a. State | 10b. County | 9 | 10c. City, | Town or Loc | ation | | | | | 10d. Inside City Limits |
| : | a-fsh | 턍 | MD | H | oward | | | | Ellico | ott City | | | 1 □Yes 2 No |
| | or 28 | Director | 10e. Street and Nu | mber | | | | 10f. Zip Code | | | 100 | . Citizen of What Co | ountry? |
| | ath w | la I | 9261 Map | le Rock Dr. | | | | | | 042 | | | .S.A. |
| | within 72 hours after death with the Maryland glene. Than "natural" or items 23a or 28a-f show Items and Examine maist to notified at | Funeral | 11. Marital Status | | 12. Was Decedent E Armed Forces? | | 13. W | as Decedent of Hi Yes, specify Cuba | spanic Ori n, Mexicar | igin? (Specify n, Puerto Rica | Yes or No- n, etc.) | 14. Race - Ame Black, White | |
| გ მ | rs aft | by F | 1 ☐ Never Mari | ried 2 Married | 1 X Yes 2 □ N If Yes, Give Year or Dates: | 3/30/ | | □Yes 2MiNo | Specify: | | | Specify: | h: to |
| 5-003p | atura | | | 15. Decedent's Ed | | 7/4/1 | 16a. Deced | ent's Usual Occupa | ation | | 16 | 6b. Kind of Business | /Industry |
| 212 | hin 7. 9. an "n Medi | Completed | (Spe | | de completed) College (1-4or 5 | +) | (Give k life. D | rind of work done d O NOT use retired, | uring mosi) | t of working | | | |
| 7 | filed within 7 I Hygiene. other than "r ent, II | S | | 12 | | | | Me | chanic | | | Auto [| Dealership |
| ם י | be filed value of the very filed | Be | 17. Father's Name | (First, Middle, Last) | | | | | 18. Mothe | er's Name (Fi | rst, Middle, Ma | iden Surname) | |
| <u> </u> | 2 should be and Menta is marked raumatic ev | ၉ | | | Elmer Ro | | | | | | | y Breckenrie | |
| Maryland | d 2 st th and 7 is n traun | | | lame/Relationship (| lype. Print) | | | , | | | | City or Town, State, | Zip Code) |
| <u>ئ</u> | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce. | | Matthew 20a. Method of Dis | S. Royer | | 20b. Plac | ce of Dispos | 1 Maple Roc ition (Name of | - 1 | Ilicott Ci | | 042 0c. Location - City of | r Town, State |
| altimore, | ages ent of tt: If it y or c | | 1 🗆 Burial 2 | Cremation 3 5 Other (Specific | Removal from State | cen | netery, cřem | atory or other place | | 0 00 | | 01 | Di. MD |
| | nit. F artm ortar Injur | Ιi | 21. Signature of F | 4. | | - | | Crematory, LI Name and Address | | Sep 02 | 2008 | Glen i | Burnie, MD |
| ñ | any per | | NWI | dilkoho | + NON+ | MAR | (2) | Slack Fu | ineral F | lome, P.A | ÷ | MD 04040 | 1 |
| | | | 23a. Part 1. Enter | the disease, or comp | plications that sadsed one cause on each lin | the death. | Do not ente | r the mode of dyin | g, such as | cardiac or re | spiratory arres | y, MD 21043 st, | Approximate Interval Between |
| P | hysician | 8 1 | Immediate Cause | (Final | | EME | | | | | | | Onset and Death |
| | /Medical | | resulting in death) | | Due to (or as | | | .1 | | | | | |
| | Examiner | L | Sequentially list or | onditions | b | | | | | | | | |
| 11 | sit ed | ine | Sequentially list co if any, leading to in cause. Enter Union Cause (Disease of that initiated event | nmediate erlying | Due to (or as | a conseque | nce of): | | | | | | |
| K | and and Il-tran | Examiner | that initiated event resulting in death) | s Last | c Due to (or as | a conseque | nce of): | | | | | | |
| 58760, | ncate be executed physician and s the burial-transit | ä | | | , | · | , | | | | | | |
| | g phy as the | edical | | | d | | | | | | | | |
| X OX | w requires that the death certific been signed by the attending p should be detached for use as | Physician/M | IF FEMALE: 23b. Was deceder | nt pregnant | 23c. If yes, outcome | | | Fata = ia maa = maa a | | | | 23d. Date of de | elivery |
| o o | deat | sicia | in the past 12 1 ☐ Yes 2 | □No | 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | | | Ectopic pregnancy Other (specify) | / | | | Month | Day Year |
| 7. | requires that the leen signed by th nould be detache | اجّ | 9 🗆 Unknowr | | | | | | | | | | |
| <u>က်</u> | res th signed | کے | Part II. Other sign | ificant conditions o | ontributing to death bu | ut not resulti | ing in the un | derlying cause give | en in Part I | | | | to the cause of death? |
| 0 | reguli een s nould | Completed | | | | | | | | | 1 ∐ Yes | 2 □ No 3 □ F | Probably 4 Nunknown |
| /\ | has b | ng l | | | | | | | | | 24a. Was an autopsy | prior to | autopsy findings available completion of cause of |
| E , | cate page | So. | | | | | | | | | perform 1 □ Yes 2 | ed? death? No 1 □ Ye | |
| ֡֝֟֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | certifi ector | B | 25. Was case refe examiner? | / | Hospital: | ./ | | Othe | | e of Death (C | heck only one |) | |
| 5 6 | rhis raldii | 2 | 1 ☐ Yes 2 ☐ 27. Manner of Dea | | 1 ☐ Inpatie | ent 2 EF | R/Outpatient 8b. Time of | 3 LI DOA | 4 🗆 N | | | ice 6 Other (Sp v injury occurred | pecify) |
| ם י | th. : Afte : fune | tion | 1 Natural 2 Accident | 5 Pending investigation | (Month, Day | | Injury | 28c. Injun Work | ?ີ Yes 2 □ | | Describe nov | rinjury documed | |
| VISION | Atter r dea ector by the | iţica | 3 ☐ Suicide | 6 Could not be | 28e. Place of Inju | ury - At hom | e, farm, stre | et, factory, office | | 28f. | | | Rural Route Number, |
| 5 . | al or s afte al Dire | Certification: | 4 ☐ Homicide | / | building, etc | c. (Specity) | | | | | City or Town, | State) | 9 |
| | to the hospital of Attending Physician: The law within 24 hours after duoing. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s | | 29a. Certifier (Check only | | nysician: To the best on the basis of | | | | | | | | |
| | the H Jin 24 the F Iplete | Medical | one) | | and manner sta | ated. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | atti occuired i | | | |
| | o 4 ¥; o | 2 | 29b. Signature and | title of certifier | | - | | 29c. License | | 1.0- | 29 | d. Date signed (Mor | ntn, Day, Year) |
| | - | | | 3 ~ ~ | 74 | DO | | | 044 | 1183 | | 8/31/2 | -008 |
| | hi | | | | complete cause of d | | | 9rint) 5450 | 17 | all No | ivth T | Drive e | olvers mm |
| | Sta | te | 31. Date filed (Mo | nth, Day, Year) | SENSTUG 32. egistra | ar's Signatur |) - U · | 9436 | ICM | ell No | VIV. | 1 | 21045 |
| | Registr | | | SEP 0 5 2 | 32. egistra | w S | K A | all! | | | | | 21048 |
| _ | | | | | | | | | | | | | |

| | | State of Maryland / De State of Maryland / Co | partment of Health and Nertificate of Death | Mental Hygie | | 18 28531 |
|---|-----------------|---|--|--|----------------------------|--|
| Physicia /Medica | | 5(),(110) | AMUELS | 2. Date of Death Month AUGUST | Day Year 28 2008 | 105 + AM |
| Examine | | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | 4b. City, Town, or Location of Death Baltimore City | Lo Date of Bidh | 4c. County of Dea | |
| Funeral Director | | 5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthda 137-58-1234 Usual Residence of Decedent | Months Days Hours Min. | 8. Date of Birth (Month, Day, Yes 4 24 | ar) 9. 60 | irthplace (State or Foreign ountry) NY |
| Maryland -f show ed at | tor | 10a. State | | | | 10d. Inside City Limits ★XYes 2 □ No |
| filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at | al Director | 10e. Street and Number 7204 McLean Blvd. | 10f. Zip-Code 21234 | 10g. | Citizen of What C | ountry? |
| of 2 should be filed within 72 hours after death with the Marylan to and Mental Hyghere. 77 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at | / Funeral | 11. Marital Status 1X Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ATNo If Yes Give | 13. Was Decedent of Hispanic Ongin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑No Specify: | pecify Yes or No- Rican, etc.) | 14. Race - Am Black, Wh | ite, etc. |
| "natural", | leted by | 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. De (Specify only highest grade completed) (G | ecedent's Usual Occupation live kind of work done during most of work te. DO NOT use retired) | | Specify: B | |
| Hygiene. ther than nt, the Me | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | rse | ne (First, Middle, Ma | Private | Homes |
| snould be filed withing and Mental Hygiene. s marked other than umatic event, the Me | To Be | Calvin Samuels 19a. Informant's Name/Relationship (Type. Print) 19b. M | Bet lailing Address (Street and Number or Ru | tty Jo | | Zip Code) |
| ages i and z sont of Health ar if item 27 is or other trau | | 20a. Method of Disposition 20b. Place of Disposition 3 ☐ Removal from State 20b. Place of Disposition | crematory or other place) | Date 200 | c. Location - City of | or Town, State |
| permit. Pages 1 and Department of Heali Important: If item 2 any Injury or other once. | | 21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee | GREEN PARK | ARCH FUN | | lle, N.J. AST e, MD 21202 |
| icate be executed bhysician and bhysician and sthe burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | 9 | PROVED BY MEDICAL | EXAMINEIL | |
| attending | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of o | delivery Day Year |
| an and ped ped ped did | þ | Part II. Other significant conditions contributing to death but not resulting in t | the underlying cause given in Part I. | 23e. Did toba | | e to the cause of death? Probably 4 |
| has been age 2 shou | Completed | | | 24a. Was an autopsy performe | ed? prior to death | autopsy findings available to completion of cause of ? es 2 \sum No |
| certifica lirector, | To Be C | 25. Was case referred to medical examiner? 1 No des 2 □ No Hospital: 1 □ Inpatient 2 No R/Outpa | Other: | th (Check only one) | | |
| or Attending Physiter death. Nirector: After this in by the funeral | ertification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify) | ury Work? 57 4M 1 □ Yes 2 🕅 No | | hicle cra- | Sh Rural Route Number, |
| Funeral | edical C | 29a. Certifier (check only one) 1 □ Certifying Physician: To the best of my knowledge, c 2 □ Medical Examiner: On the basis of examination and/one) 1 □ Certifying Physician: To the basis of examination and/one) | | e, and due to the cau | use(s) and manner | |
| To the comple | Me | 29b. Signature and title of certifier | 29c. License number RES 000 | | J. Date signed (Mo | onth, Day, Year) |
| 6 | | 30. Name and address of person who completed cause of death (Item 23a) (TSAMIT DESAI | | | | nore, MD, 21287 |
| Sta Registra | | 31. Date filed (Month, Day, Year) 32 Registrar's Signature | have a | | | |

| | | | Pleas | se Type or Pri | | | delible Ink artment of h | | | | | | . Ω | 285 | 775 |
|------------|---|------------------|---|---|--------------------------------|-----------------------------|--|---|---------------------------|--|--------------|--------------------------------------|---------------------|-------------------------------|--------------------|
| | | | State Registrar | | | Cei | rtificate of | Death | | | Reg. No | . 200 | U | 200 | |
| Н | Physici | an | Decedent's Name (First, Middle) | | | | | | | Date of De Month | Da | | | 3. Time of D | |
| · · | /Medic | al | LILLIAN (| HO TI | | | 41: Oh Tour | | of Dooth | 09 | 0.3 | . County of D | 9 | 10:30 | AM |
| | Examin | er | 4a. Facility Name (If not institution, |) _ | | ~~~ | 4b. City, Town, o | | of Death | | 40 | . County of D | eatn | | |
| - 4" | Funeral | | 0 11113 | 6. Sex 7. Ag | je (In yrs. la | EN TER ast birthday) | If Under 1 Year | If Under | | 8. Date of Bi | irth | 9. 1 | Birthpla Country | ce (State or I | Foreign |
| | Director | | 217-07-6051 | 1□M 2Ã F | 88 | Yrs. | Months Days | Hours | Min. | 6-5-1 | 1920 | | Md. | ·/ | |
| | and w. | 1 | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | - | | | | 100 | I. Inside City | Limits |
| | Maryl | to | Md. | | Re | altimo | ro | | | | | | | Yes 2 | No |
| | n the | Director | 10e. Street and Number | | Бе | art Lino | 10f. Zip Code | | | | 10g. Ci | tizen of What | Country | y? | |
| | 23a c | la | 155 Grundy St | reet | | | 21224 | | | | | J | SA | | |
| 396 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evan that the notified at or other traumatic event, the Medical Evan that the notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? ed 1 Tyes 2 Till If Yes, Give Year or Dates: | • | 1 | Was Decedent of H If Yes, specify Cub 1 □ Yes 2∑No | Hispanic Ori an, Mexicar Specify: | igin? (Spe n, Puerto F | cify Yes or N Rican, etc.) | 0- | 14. Race - A Black, W Specify: | hite, etc | | |
| 2-0 | 72 hou | ted | 15. Decedent | 's Education | | 16a. Dece | dent's Usual Occup | pation | t of workin | | 16b. K | (ind of Busine | ss/Indu | stry | |
| 21215-0036 | ithin 7 ne. "ran "r | Completed | (Specify only highes Elementary/Secondary (0-12) | College (1-4or | 5+) | | kind of work done DO NOT use retire | d) | t of working | g | | | _ | | |
| | Hygier Hygier ther th | | 9th 17. Father's Name (First, Middle, L | acti | | Cler | k | 19 Motho | r's Namo | (First, Middle | | rance Sumame) | Com | pany | |
| and | buld be fi Mental B arked of atic ever |) Be | Bud Martin | _dst/ | | | | 1 | | Patte | | | | | |
| Maryland | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma | 오 | 19a. Informant's Name/Relationsh | nip (Type. Print) | | 19b. Mailir | ng Address (Street | | | | | | e, Zip C | ode) | • |
| | 1 and 2: Health a tem 27 Is | | Sandra Yingli | ng | | 4701 | Ballvga | r Rd. | Nott | inghar | n. Mo | 1. 2123 | 36 | | |
| ore | of He of He filtern | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | | 20b. Pla | | sition (Name of matory or other pla | | | ate | | ocation - City | | n, State | |
| Ë | Pages ment of lant: If Ite | | 4 □ Donation 5 □ Other (Sp | | Sacı | red He | art of J | esus | - | 2008 | i . | Oundall | | | |
| Baltimore, | permit. Pages Department of Important: If I any Injury or once. | | 21. Signature of Funeral Service L | Licensee | | 22 | 2. Name and Address 9705 Be | | - | | | meral | | | |
| | HD = # 0 | \vdash | 23a. Part1. Enter the disease, or | complications that cause | d the death | Do not ont | | | | | | , riu - 2.1 | | Approximate | |
| | | | shock, or heart failure. List of Immediate Cause (Final | only one cause on each li | ine. | ٥ | | 6 | | respiratory | arrest, | | 1 1 | nterval Betwe Onset and De | |
| 1 | Physician /Medical | | disease or condition resulting in death) | Due to (or as | a conseque | | RATERY | TAIL | upe | | | | +- | day | |
| | Examiner | | | ~ ~ | mw LA | , | | | | | | | (| WEE | TIC |
| | fo .t= | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | | | | | | | | | | | |
| >,00 | icate be executed physician and s the burial-transit | l Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as | a conseque | ence of): | | | | | | | | | |
| 9289 | physic physic the b | dica | , | d | | | | | | | | | - | | |
| O. Box 6 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant a | 2 Fetal | death 3 [| ☐Ectopic pregnand ☐Other (specify) _ | су | | | | 23d. Date of Month | | | ar |
| ٩, | s that med b e deta | by Pt | Part II. Other significant conditio | ns contributing to death b | out not resul | lting in the u | nderlying cause gi | ven in Part I | | 23e. Did | tobacco | use contribut | e to the | cause of de | ath? |
| Records, | w requires been sign should be | ed b | | | | | | | | 1 | Yes 2 | P No 3□ |] Proba | bly 4 Ur | hknown |
| ecc | e law re has be je 2 sho | Completed | | | | | | | | 24a. Wa | s an opsy | 24b. Were | autops | sy findings av | vailable use of |
| = R | . The | Com | | | | | | | | per 1 □ Yes | formed? | deat | | | |
| Vital | Physician: The this certificate af director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | | Ott | | e of Death | (Check only | one) | | | | |
| of | Phys r this raf dir | 잍 | 1 ☐ Yes 2 🕅 No 27. Manner of Death | 1 X Inpati | | ER/Outpatier 28b. Time o | IL 3 LI DOA | | | ne 5 Re | | 6 Other (| Specify) | | |
| on | nding Ph th. : After th : funeraí | tion | 1 Natural 5 Pending 2 Accident investig | (Month, Da | ay, Year) | Injury | Wo | rk?]Yes 2□ | | ou. Describe | 5 110W 111JC | ny doddined | | | |
| Division | or Atter frer dea irector n by the | Certification: | 3 Suicide 6 Could n 4 Homicide determi | ot be 28e. Place of In | jury - At hor tc. (Specify, | me, farm, str | eet, factory, office | | 2 | | (Street a | and Number o | Rural . | Route Numb | er, |
| Ω | pital o | | 29a. Certifier 1 Certifyin | # Physician: To the heat | t of my know | uladaa daat | h accurred at the t | ima data a | less . | and due to th | | 'a) and mann | r oo oto | atod | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, | Medical | | g Physician: To the best Examiner: On the basis and manner s | of examinati | ion and/or in | ivestigation, in my | opinion, dea | ath occurr | ed at the time | e, date ar | nd place, and | due to t | the cause(s) | |
| _ | To t To t | Σ | 29b. Signature and title of certifier | | | | 29c. Licen | | | | 29d. D | ate signed (M | onth, D | ay, Year) | |
| | | | | | cior | | RES | 100 | | | 09/ | 03/08 | | | |
| | (0 | | 30. Name and address of person v | 1 | _ | | | | | | | , | | | |
| | Sta | te | PATELCK SATO NO. 31. Date filed (Month, Day, Year) | / | rar's Signati | | rue, DALT | Imore | - M |) , 21 | 224 | | | | |
| | Registr | | SFP 0 | 5 2008 | 5.45 a | K | back | | | | | | | | |
| | | | C Ring 6 | - | DW | | - | | | | | | | | |

08-06731 William Seifert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 28536

| | | - For State | Certific | ate of Deatl | h | Reg. I | No. | |
|--|----------------|--|--|--|---|-----------------------|------------------------------------|----------------------------|
| Physicia | n/ | 1. Decedent's Name (First, Middle,La | est) | | Date of Death Month Da | ay Year | 3. Time of Death | |
| ledical Examir | | William | 1. SEIFER | 7 | Ţñ | September 2 | , 2008 | 2255 hrs |
| | | 4a. Facility Name (if not institution, g | | 1 | own, or Location of Death Marsh | | 4c. County of Deat Baltimore Co | |
| | | 4406 Freestone Lane #2 | | | | O Date of Birth (| MM/DD/YYYY) g. Bi | |
| Funeral | | _ | Sex 7. Age (In yrs. last bir | thday) If Under | er 1 Year If Under 24Hrs s Days Hours Min. | - | Forei | gn MARY LAND |
| Director | | 1 2886 PH SIR | M 2 F 63 | Yrs. | | 5287-30 | 10411 0 | ountry) |
| 8 | - | Usual Residence of Decedent | 10c. City, Town | or Logation | | | 1 | 10d. Inside City Limits |
| w any | | 10a. State 10b. County | Toc. City, Town | TOT LOCATION | | | | 1 Yes 2 No |
| Aaryland 28a-f show 1 at once. | į | 110111111111111111111111111111111111111 | VOL55 112 | 1111276 | 200 | 100 | Citizen of What Co | |
| Mary r 28a | Director | 10e. Street and Number | 1 | 10f. Zip | Code | Tog. | i i i i i | and y: |
| with the Maryland ms 23a or 28a-f sho be notified at once | | HAOPL (5252) OC | 5 YOUR HAL 94 | 24 9 | 1836 | | U-S.P | rican Indian, Black, |
| ith wi | uneral | 11. Marital Status 1 Never Married 2 Marrie | 12. Was Decedent Ever in U.S. Armed Forces? | If Yes, specif | ent of Hispanic Origin?(Sp fy Cuban, Mexican, Puerto | Rican, etc.) | White, etc. | ricali ilidan, biack, |
| er death | 교 | | Yes 2 No | 1 Ves 2 | No specify: | | Specify: \) | 37. H |
| rs afte | <u>a</u> | 15. Decedent's Education (Specify | or Dates: | | Occupation (Give kind of | vork done 16 | 6b. Kind of Business | Industry |
| 2 hou "nat | ted | Elementary/Secondary (0-12) | College (1-4 or 5+) | during most of wo | rking life. DO NOT use reti | red) | | |
| thin 7 | 힏 | 12/05 | 0. | 57 TH. Si | SW LAPTA | in li | SUPERF | H238 |
| 5-0036 led within 7: Hygienc. other than | Complet | 17. Father's Name (First, Middle, La | st) | | 18.Mother's Name | (First, Middle, Mai | den Surname) | |
| 21215 uld be fill Mental Fi marked c event, I | Be | ZILSAHZ | SEIFERT | < | NORC | IA L | 311HW | |
| AD 21215-0036 2 should be filted within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once | P | 19a. Informant's Name/Relationship | | Appendix. | (Street and Number or | Rural Route Numbe | er, City or Town, Sta | te, Zip Code) |
| MD d 2 sho lth and n 27 is | | BONNIE J. S | Red 1 Pert 1 Pert | 170P F.G. | 3 4 300 TLLS | JUE HEL | 101 HOB | OT MAHESTIT |
| more, ME Pages I and 2 s nent of Health at ant: If item 27 | | 20a. Method of Disposition 1 | | of Disposition (Na atory or other place | | Date 7 | 20c: Location - City | or rown, state |
| Page Page | Ш | 4 Donation 5 Other Spen | | 2 Rocins | 6 7258 | 608 | 5 ARRIGIO | MAKBAL OC |
| Baltim permit. Pag Department Important: injury or o | 1 | 21. Signature of Furieral Service Lice | rensee | 22. Name and | Address of Facility | HARZLAR | Anssza | 110/ DRV1037 |
| 2.2.2.6 | 2 3 | Mad Know | 10 | 38,00 | MARTICO | ROAD PAR | KN1795 W | Approximate Interval |
| Physician /Medical | | 23a. Part I. Enter the disease, or co failure. List only one cause on | | not enter the mode | or dying, such as cardiac | or respiratory arrest | , SHOCK, OF HEAR | Between Onset and Death |
| xaminer | 1 | Immediate Cause (Final disease or condition resulting in death) | a. Peritonitis | | | | | Deatil |
| | | | Due to (or as a consequence of): b. Dehiscence of Surgical Wo | ound | | | | |
| | ē | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence of): | | | | | |
| | Examiner | (Disease or injury that initiated | c. Due to (or as a consequence of): | | | | | |
| E C is | Ex | events resulting in death) Last | d. | | | | | |
| 760, cate be executed physician and he burial - transit | <u>ह</u> | UNPENDED | AMENDED | - | | | | |
| 760, icate be physiciate the buria | Medical | IF FEMALE: | 23c. If yes, outcome of pregnance | | | | 23d. Date of deliv | ery |
| | | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | 2 Fetal death | 3 Ectopic pregn | ancy | Month | Day Year |
| Box 687 death certific the attending | sici | 1 Yes 2 No 9 Unkno | 4 Pregnant at time of death | 5 Other (Sp | ecify) | | Vi. | Ì |
| be de fined f | Physician | | Unknown s contributing to death but not result | ing in the underlyin | n cause given in Part I | 23e. Did tob | acco use contribute | to the cause of death? |
| Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | ξ | Colon Cancer | io continuating to accur but not record | ang mano anaony m | g cases g | 1 Yes | 2 No 3 P | robably 4 Unknown |
| ords, w required is been signatured by the should be | Completed by | Goldin Galloci | | | - | 24a. Was ar | | autopsy findings available |
| COFC law re has be 2 sho | ple | | | | · | autopsy perform | | o completion of cause of ? |
| tal Rec tian: The certificate ector, page | Ö | | | | | 1 ✓ Yes 2 | No 1 ✓ | Yes 2 No |
| Vital Rec ysician: The l his certificate director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | 26.Place of Death (Check | | tesidence 6 🗸 Ot | har Cana |
| | ပ္ | 1 ✓ Yes 2 No 27. Manner of Death | i inpatient z Liv | Outpatient 3 | DOA Other 4 Nurs 28c. Injury at Work? | | ow injury occurred | iler. Scelle |
| n of Iding Pl h. : After e funera | on: | 1 Natural 5 Pendin | (Month, Day,Year) | or range or ragery | 1 Yes 2 No | | | İ |
| IVISION or Atten after death Director: | cat | 2 Accident Investi | | farm street factor | v. office building, etc. | 28f. Location (St | reet and Number or | Rural Route Number, City |
| Division of ¹ Ospital or Attending Ph hours after death meral Director: After t | Certification: | 3 Suicide 6 Could | not be | ,,, | ,, | or Town, Sta | | |
| spi ner fil | | 29a. Certifier | sician: To the best of my knowledge, o | death occurred at the | ne time, date and place, ar | d due to the cause | (s) and manner as s | tated. |
| To the Hospital within 24 hours. To the Funeral completely filled | edical | (Check only one) 2 Medical Exam | iner:On the basis of examination and/o | or investigation, in r | ny opinion, death occurred | at the time, date a | nd place, and due to | the cause(s) |
| 7. w T. | Me | 29b. Signature and title of certifier | and manner stated. | 2 | 9c. License number | | 29d. Date signed (| Month, Day, Year) |
| | | Down Did | - I MD | | O.C.M.E. | | September 3, | 2008 |
| 151 | | 30. Name and address of person w | ho completed cause of death (Item 23a | | | | | - |
| r | | Donna M. Vincenti, MD | Assistant Medical Examine | er 111 Penr | Street, Baltimore, | MD 21201 | | |
| S Regis | | 31. Date filed (Month, Day, Year) | 32. Registar's Signature 5 2008 | & Coose | E) | | | |
| 3(4)) | 146516 | ~FP U | 1) FONO LONGAGE | 1 | | | | |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, perMD G883 9/5/08 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2008^{Year} **Physician** 9:15A M Aug. 26 Florence Virginia Serra /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale 5300 Balistan Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | DeC . 26, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 218-12-6157 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at Baltimore Rosedale 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5300 Balistan Road 21237 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t and 2 should be findestill Health and Mental H is marked Christina Gullotta Louis Grue 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valerie A. Reich/daughter 212 Dade Court Dallastown PA 17313 of Health Item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important; If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Garrison Forest 8/29/08 Owings Mills 4 Donation 5 Dother (Specify) Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HTW Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne∗ of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: il or Attending Fafter death. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD0058656 AUGUST 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER DRIVE TOUSON, MARYLAND 21204

Registrar DHMH 17 Rev 1/2001 MARK SABA MD

0

31. Date filed (Month, Day, Year)

2346

Registrar's Signature

| | | | For State | | State of | Marylan | | rtment of I tificate of | | nd Ment | | 7111 | 18 | 28538 |
|----------------------------|---|----------------|---|-----------------------------------|--|--------------------------------------|---------------------------------|--|----------------------------------|--------------------------|------------------------------------|-----------------------------------|---------------------------|---|
| | | | Registrar 1. Decedent's Name (First | t. Middle. Last) | | | Cei | - Inicate of | Death | 2. D | ate of Death | No. 2 0 | | 3. Time of Death |
| | Physicia | | | | Cah I | udosh. | 0.74.04 | | | N | Nonth | Day Ye | ear 98 | 10:57 pm |
| | /Medic Examin | | Freder 4a. Facility Name (If not in | | | | erg | 4b. City, Town, o | or Location of D | l Death | | 4c. County of I | | in a pri |
| | Examin | - | FRANKLIN V. | JUARE | HOSP:7 | Ol PEN | HER | RASI | ENALE | | | BALT | time | RF |
| | Funeral | | 5. Social Security Number | 6. Sex | 7 | . Age (In yrs. I | ast birthday) | If Under 1 Year Months Days | If Under 24 Hours | Hrs. 8. D | ate of Birth Month, Day, Y | 9. | . Birthplac | ce (State or Foreign |
| | Director | | 219-32-392 | 2 x | M 2□ F | 7. | 2 Yrs. | Months Days | Hours | Ap | ril22 | ,1936 | Country | MD |
| | pu s | | Usual Residence of Deced | dent County | | 10c Cit | , Town or Lo | ration | | | | | 104 | . Inside City Limits |
| | laryla sho | 5 | | altimo | re | 100. 010 | Ess | | | | | | 100 | 1 ∐Yes 2. No |
| | the N | Director | 10e. Street and Number | ar crim | J1 C | | 135 | 10f. Zip Code | | | 100 | . Citizen of Wha | at Country | 2 |
| | aa or | | 917 Kinw | at Ave | enue | | | 212 | 21 | | 1.09 | USA | | |
| | ms 2 | Funeral | 11. Marital Status | - | 12. Was Deced | ent Ever in U. | S. 13. \ | Vas Decedent of | Hispanic Origin | ? (Specify ` | Yes or No- | 14. Race - | | |
| စ္ | be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Econinar must be notified at | / Fu | 1 Never Married 2 | Married | Armed Ford 1X Yes 2 If Yes, Give | No | | fYes, specify Cub I∐Yes 2 ⊠ No | | derto Ricar | n, etc.) | | White, etc ماري | |
| 21215-0036 | ural", | d by | 3 Widowed 4 D | ivorced | Year or Da | es: | | ILITES ZLANO | Ореспу. | | | Specify: | | ite |
| 2 | "nati | Completed | 15. De (Specify only | ecedent's Educ y highest grade | cation completed) | () | (Give | dent's Usual Occu kind of work done | during most of | f working | 16 | b. Kind of Busir | ness/Indus | stry |
| 12 | withir ene. than | ğ | Elementary/Secondary (| (0-12) | College (1- | for 5+) | | 1 Worke | , | | | Beth S | tee | 1 |
| | filed within 72 I Hygiene. other than "na ent, the Medic | ပ္ပ | 12th 17. Father's Name (First, I | Middle, Last) | | | | - 1101710 | T | Name (Firs | | iden Surname) | | |
| an | Mental Mental arked o | To Be | Frederic | | Schlud | erber | g | | I | Rosen | ary Z | ahner | | |
| Maryland | shot m | - | 19a. Informant's Name/Re | elationship (Ty) | pe. Print) | | 19b. Mailin | ig Address (Stree | t and Number o | or Rural Ro | ute Number, C | City or Town, Sta | ate, Zip C | 'ode) |
| | and 2 fealth a m 27 is her tra | | Juanita | L. Scl | nluder | berg | 917 | Kinwat | Avenu | ue Ba | ltimo | re MD | 212 | 21 |
| altimore, | ~ T O = | | 20a. Method of Disposition | | | 1 0 | emeterv. cren | sition (Name of natory or other pla | ice) | Date | | c. Location - Cit | ty or Tow | n, State |
| Ĕ | Pages ment of ant: If It ury or o | | t Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ C | | emoval from S | tate Ho | lly H | ill Cem | etery | 9/5/ | 08 | Baltim | ore | MD |
| Balt | permit. Pages Department of Important: If It any Injury or o | | 21. Signature of Puneral S | Service License | e /) | 21 | 11 | . Name and Addr | | 300 | Mace | Ave. E | Balte | o. MD |
| _ | TO = # 0 | | Colex | Ilu | 1 Caro | elly | | Connell | | | | | | |
| | | | 23a. Part 1. Enter the dise shock, or heart failui | re. List only or | cations that ca | ch line. | n. Do not ent | er the mode of dy | ing, such as ca | ardiac or res | spiratory arres | τ, | l li | Approximate hterval Between Onset and Death |
| Page 1 | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | 8 | | 19 Car | | | | | | | | |
| and . | Examiner | | resourcing in addition | • | Due to (c | r as a consequ | uence of): | | | | | | | |
| | | er | Sequentially list conditions if any, leading to immediate | s, te | Due to (c | r as a consequ | uence of): | | | | | | | |
| | ansit ansit | Examiner | Cause (Disease or injury | _ | | , | | | | | | | 1 | - 1 |
| ń | an an rial-tra | Еха | that initiated events resulting in death) Last | · · | Due to (c | r as a consequ | uence of): | | | | | | | |
| 58760, | ificate be executed g physician and as the burial-transit | dical | | | l | | | | | | | | | |
| 39 | | | IF FEMALE: | | | | | | | | | Т. | | |
| Вох | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as | Physician/M | 23b. Was decedent pregn in the past 12 month | Idilit | | rth 2 🗖 Feta | Ideath 3□ | ∃Ectopic pregnan | су | | | 23d. Date of | | / Pay Year |
| 0 | the a | /sic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | 4 ∐ Pregna 9 ☐ Unkno | ant at time of d wn | leath 5 | Other (specify) | | | | 10000 | | ., |
| J. | hat the sd by detac | | Part II. Other significant of | conditions cor | tributing to dea | ath but not resu | ulting in the u | ndertving cause g | ven in Part i | | 23e. Did toba | cco use contrib | ute to the | cause of death? |
| ds, | w requires that the de been signed by the should be detached | d by | J | | | | | , 9. | | | | | | bly 4 🔽 Unknown |
| Š | v requ been shoul | ete | | | | | | | | | 040 Woo on | O4h We | re auton | sy findings available |
| Ř | ne law e has ge 2 s | Completed | | | | | | | | - | 24a. Was an autopsy performe | pric | or to com ath? | pletion of cause of |
| ā | slcian: The le certificate ha rector, page 2 | မ င် | 25. Was case referred to | medical | | | | | 00 Pl | | 1 □Yes 2 | V No 1□ | Yes 2 | No |
| > | /slcia s ceri | To B | examiner? | _ | lospital: | patient 2 🗆 | EB/Outnatier | ot 3 🗆 DOA Ot | her: | | eck only one) | ce 6 □Other | (Spacify) | |
| 0 | g Ph er thi | n:T | 27. Manger of Death | | 28a. Date o | | 28b. Time of | f 28c. Inju | ıry at | | | injury occurred | | |
| 0 | ath. rr: Aff | atio | 2 🗖 Accident | Pending investigation | {WOIN | , Day, rear) | Injury | | rk? ∐Yes 2∐No | 0 | | | | |
| Division of Vital Records, | r After ter de irecto | Certification: | 3 ☐ Suicide 6 ☐ 4 ☐ Homicide | Could not be determined | 28e. Place o buildin | of Injury - At ho g, etc. (Specif | ome, farm, str | eet, factory, office | | 28f. l | ocation (Stre | et and Number State) | or Rural | Route Number, |
| | intal o | | | | | | | | | | | | | |
| | To the Hospital or Attending Physician: within 42 hours dater death. To the Funeral Director: After this certifics completely filled in by the funeral director, p | Medical | 29a. Certifier 1 V C (Check only 2 N | ertifying Phys ledical Exami | sician: To the ner: On the ba and mann | sis of examina | wledge, deat ition and/or in | h occurred at the vestigation, in my | time, date and opinion, death | place, and occurred a | due to the car t the time, dat | use(s) and man e and place, an | ner as sta id due to t | ited. he cause(s) |
| | To the within Fo the complex | Me | 29b. Signature and title of | certifier | | | - | 29c. Licer | se number | | 290 | d. Date signed (| Month, D | ay, Year) |
| | | | 1 | | MP | | | I | 3660 | 63 | 1 6 | 3/31/08 | | |
| | i | | 30. Name and address of | | | | | Print) | | | , | | | |
| | 6 | ii i | DR. WILLES, S | STUAR- | TMD 9 | ODO FR | PANKLI | NSQUARE | DRIVE | BALL | HIMURE | MARYL | AND | 21237 |
| | Sta | te | DR. WILLES, S | y, Year) | 32. Re | gistrar's Signa | ture & | GORALI | | | | 7 | | |
| 4 | Registr | ar | S | ELAD | 2000 | CHARLES AND | - / | | | | | | | |

SchluderBerg, Frederick

State of Maryland / Department of Health and Mental Hygiene 28539 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Juanita Velma Scarff 2008 4:05 A M September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year)
Feb. 17, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Yrs 219-56-4158 Director 1914 Virginia Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be notified at 1 □Yes 2X No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 Watervale Road 21047 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2 TNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Mac Irwin ပ Maye (nmn) Hoppers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irwin Scarff Sr. / Son 1206 Watervale Road, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion U.M.C. Cem. 9-5-08 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): Acquired disease or condition resulting in death) in known /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner s a consequence of) law requires that the death certificate be executed Diabetes Mellitus unknown and burial-tran Due to (or as a consequence of) physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 24a. Was an autopsy perform 1 □Yes 1 ☐ Yes the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c Medical Certification: To Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 enauxel H.D. D0060248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J C Gvecuawalt M. D. 6701 North Charles Street Towson, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Specie SEP 05 Registrar

DHMH 17 Rev 1/2001

SCARFF, Juanita 3altimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? | | | | For State Registrar | | State of Ma | aryiand | | tificate | | | ептаг пу | gierie _{Reg. No.} 2 | 800 | 2854 | 0 |
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| Manufacture of Control The State The | İ | | | 5. Social Security Number | r 6. Se | 7. Ag | e (In yrs. las | | | | | | th y, Year) | 9. Birthp Cour | place (State or Foreigntry) | ın |
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| Physician Medical Examinor Ph | Balti | permit. Departn Imports any injt | | 21. Signature of Funeral | Service Licen | See | | 22 | . Name and A | ddress of | Facility Rap | p Funer | al & | Cremat | ion Servi | CE |
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| State Stat | rds, r. | quires that n signed by | by | Part II. Other significant | conditions co | entributing to death b | ut not resulti | ng in the ur | derlying caus | e given in | Part I. | | | | | 'n |
| 25. Was case referred to medical examiner? | несо | The law recate has bee page 2 shoo | omplete | _ | | | | | | | | auto perfe | psy prmed? | prior to co death? | empletion of cause of | е |
| 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ANA KAUFMAN MD 82/8 WISCONSIN AVE, SEZIVE SINA MID State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | V Ita | Iclan: sertific setor, | a l | 25. Was case referred to examiner? | | | | | | | | (Check only | one) | | | |
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| 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ANA KAUFMAN MD 82/8 WISCONSIN AVE, SEZIVE SINA MID State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | | ne Hospit n 24 hours ne Funera | | (Check only 2 1 | ertifying Ph Medical Exam | iner: On the basis o | f examinatio | edge, death n and/or in | occurred at tweetigation, in | he time, o my opinio | date and place, on, death occurr | and due to the red at the time | cause(s) and pla | nd manner as a | stated. o the cause(s) | |
| 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) AUA KAUFMAN MO 82/8 W/S CONSIN AVE, SEZIES SOA MOD State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | | To the within the complete com | M | 29b. Signature and title of | f certifier | 1 | | | 29c. Li | cense nur | mber | | 29d. Date s | igned (Month, | Day, Year) | |
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| | _ | iotl | | 30. Name and address of | person who d | omplete cause of d | | 3a) (Type, I | Print) | 110 | int a | 15 1 | = 211 | E (A | AMO | |
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death A 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28, 2008 Month **Physician** rrel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Apti カ (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 27, 1940 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex **Funeral** Min. Months Hours -0469 1 □ M 200 F -38 Marylano Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 'naturel', or items 23a deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X)No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be re ShingTon 2 19a. Informant's Name/Relationship (Type, Print) (n'iece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kahinson JMI 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) permit. Pages 1 Department of P Important: If its eny injury or ot ong. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph 2222 V KUS W. North Ave. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8 month disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No 2 🗷 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death.
I Director: Aft
d in by the fun 1 🗌 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide hours after within 24 hours a To the Funeral [illed 1 💆 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29s Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and a dress of Terson

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2008

31. Date filed (Me

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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| 1 | For State Certificate of Deatri | Reg. No. 2. Date of Death 3. Time of Death |
| Physician/ | egistrar Decedent's Name (First, Middle, Last) | Month Day Year 0347 hrs September 2, 2008 |
| Med Examiner | Titus Simeona (4b. City, Town, or Location of Dea | ath 4c. County of Death |
| | a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Glen Burnie | Anne Arundel |
| | 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 | Country) |
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| with the Maryland s 23a or 28a-f show s c notified at once. | 15 Independence Ave 113 / S Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? | (Specify Yes or No- 14. Race - American Indian, Black, |
| r death with or items 23. must be no Funeral | 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Pu | erto Rican, etc.) White, etc. |
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| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Completed by Funeral Director | 10a Informant's Name/RelationShip (Type, Fills) / (Y) CTL 2 [] | er or Rural Route Number, City or Town, State, Zip Code) |
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| and 2 and 2 lealth item 7 | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) | 1/6/2008 Hempstead N.Y. |
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| altin nit. P sartme portan | 21 Signature of Funeral Service Licensee 22 Name and Address of Facility 23 Signature of Funeral Service Licensee 24 Donation 5 Other Specify 25 Name and Address of Facility 26 Seph | Fungral Home, P.f. |
| B Per Tili | 232 Part I. English the disease, or complications that caused the death. Do not enter the mode of dying, such as care | diac or respiratory arrest, shock, or heart Between Onset and |
| - 'ysician | 23a/Part I. Entire the disease, or complications that causes the disease and failure. List only one cause on each line. Immediate Cause (Final disease a. Alcohol & narcotic intoxication c | omplicated by cocaine Death |
| ledical _xaminer | Immediate Cause (Final disease or condition resulting in death) a. Alcohol & narcolle littoxicaters or some of the condition resulting in death) Due to (or as a consequence of): use | |
| | b | |
| | Lie as le asing to immediate Due to for as a consequence of. | |
| ed | (Disease or injury that initiated events resulting in death) Last | |
| ecuted and transit | 22 27 29g f perME G883 9 | /11/08 TT |
| e exection a cian a | X UNPENDED AMENDED Z3a, Z7, Z6a-1, Perim, G555 3. | 23d. Date of delivery |
| Pox 68760, the death certificate be exe by the attending physician ched for use as the build. | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Sb. Was decedent pregnant in the | pregnancy Month Day Year |
| certif | past 12 months? 4 Pregnant at time of death 5 Other (Specify) | |
| BOX death the att | 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part | rt I. 23e. Did tobacco use contribute to the cause of death? |
| P.O. es that the igned by oe detach | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in a | 1 Yes 2 No 3 Floodby |
| S, P uires t uires t Id be o | | 24a. Was an 24b. Were autopsy findings available prior to completion of cause of |
| ord: | 26.Place of Death | performed? death? 1 Yes 2 No 1 Yes 2 No |
| Rec The la | 26.Place of Death | |
| tal F cian: certifi ector, | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other | Nursing Home 5 Residence 6 Other: |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rea after death. Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach. | O 1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work | |
| n of \alpha of \alpha of \bar{\chi}. th. The After the funeral | 27. Manner of Death (Month, Day, Yaer) 1 Natural 5 Pending Fnd 9/2/08 Fnd 2:52 am 1 Yes 2 X | No unk |
| ivision for Attendi after death. Director: | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, e | tc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8244 Lexington Dr |
| Divi | determined (Specify) | Severn, MD |
| Hosp 24 hou Fune stely fi | | ace, and due to the cause(s) and market courred at the time, date and place, and due to the cause(s) |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Fro the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiconness. | and marries states | 29d. Date signed (Monthly 2-7) |
| 200 | 29b. Signature and title of certifier O.C.M.E. | September 2, 2008 |
| 8 | 30. Name and address of person who completed cause of death (Item 23a) | |
| A | 30. Name and address of person who completed cause of dealt (non-255) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltin | more, MD 21201 |
| 3 | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | |
| Regis | rar SEP 0 5 2008 | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 08 31 11 f1843 BM Kenneth Dale Short 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. AGNES HOSPITAL BALTIMORE **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 M 2 F Director MD 220-14-4206 82 Sep 23, 1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nottified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 No Funeral Director Catonsville MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 1914 Rollingwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 D Yes 2 D No 1 Res, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 7/14/1943 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) law lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Joseph George Short Lillian Magaha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 Rollingwood Road Catonsville, MD 21228 Anne Short Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sep 04, 2008 Ellicott City, MD St. John's Cemetery 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Slack Funeral Home, P.A. 2871 Old Columbia Pike Ellicott City, MD 21043
23a. Part1. Enter the disease or complications that of use of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, larged on the columbia Pike Ellicott City, MD 21043
25a. Part1. Enter the disease or complications that of use of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, larged on the columbia Pike Ellicott City, MD 21043
25a. Part1. Enter the disease or complications that of use of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, larged on the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) clocksidium **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PECENT PNEUMONIA 1 ☐ Yes 2 X No 3 Probably 4 □Unknown Be Completed . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Jry1

Baltimore, Maryland 21215-0036

P.0.

Vital

Division or

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

0 0 5 2000 pages so figure

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20 966

900 S. CATON AVENUE, BALTIMORE, MD 21229

08,31,2008

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|----------------------------|--|---------------------------|--|--|-------------------------------------|---|--|--|---|----------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | - Incate of | | Reg. No. | | 3. Time of Death |
| | Physicia /Medic | | Charles B. To | orie | | | | Hug 30 | 2008 | 1807 M |
| 100 | Examin | | 4a. Facility Name (If not institution, give st | reet and number) | 0- 10- | | r Location of Death | 40 | County of Deatl | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In y | entor | If Under 1 Year | DULY If Under 24 Hrs. 8 | . Date of Birth | 9. Birti | hplace (State or Foreign |
| | Director | | | M 2□F 85 | Yrs. | Months Days | Hours Min. | 12/16/192 | 22 00. | untry) IN |
| | and www. | | Usual Residence of Decedent 10a. State 10b. County | 10c. | City, Town or Lo | ecation | | | | 10d. Inside City Limits |
| | Maryl t-f sho | tor | PA Alleghe | eny | | Pitts | burgh | | | 1 □ Yes 2X No |
| | or 28s | Director | 10e. Street and Number | | | 10f. Zip Code | .005 | 10g. C | Citizen of What Co | untry? |
| | s 23a | | 999 Waldwick Driv | | 110 | | 3237 | 6. Va a or Na | USA | vices Indian |
| 98 | should be filed within 72 hours after death with the Maryland and Mertal Hyglene. In arrived other than "natural", or items 23a or 28a-f show matic event, if a Marylad Examir or must be redified at | y Funeral | 1 ☐ Never Married 2 ☐ Married | 2. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No A If Yes, Give | Ymr. | was Decedent of F If Yes, specify Cuba 1 □ Yes 2 🖺 No | Hispanic Origin? (Speci an, Mexican, Puerto Ric Specify: | can, etc.) | 14. Race - Ame Black, White Specify: Wh | |
| 21215-0036 | hours tural", | ed by | 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education | Year or Dates: WW | II | dent's Usual Occup | | 16h | Kind of Business/ | |
| 215 | hin 72 9. an "na | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | (Give | | during most of working | TOD. | Talla of Basiliess/ | industry . |
| 21 | filed wit Hygiene ther tha | Con | 12 | 4 | C: | ivil Engi | | | Stee | L |
| and | d be fill ental H ced otl |) Be | 17. Father's Name (First, Middle, Last) Alex Torie | | | | 18. Mother's Name (i | | n Surname) | |
| Ž | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffed at ance. | To | 19a. Informant's Name/Relationship (Type Charles Torie / Sc | | | | and Number or Rural lood Drive, | | | |
| altimore, | es 1 a of Hei of Item | | 20a. Method of Disposition 1 → Surial 2 □ Cremation 3 → Re | | b. Place of Dispo cemetery, crea | osition (Name of matory or other place | | | Location - City or | |
| <u>Ħ</u> | permit. Pages Department of I Important: If Ite any injury or of | | 4 ☐ Donation 5 ☐ Other (Specify) | | | Park Cem | | /2008 | Merrilly | 7ille,IN |
| Ba | permit. Departr Importa any inju | | 21. Signature of Funeral Service Licepse | Dorota W. | Marshal ² | Name and Addre | s L. Steve | ns Fune <u>r</u> a | 1 Home | Inc. |
| | _ | | 23a. Part1. Enter the disease, or complic | ations that caused the d | eath. Do not en | | Cast Fort A ng, such as cardiac or | • | iltimore, | Approximate Interval Between |
| 14 | Physician | | shock, or heart failure. List only one Immediate Cause (Final disease or condition | cause on each line. | 1. Mu | ocambal | 1 Latoro | Lina | | Onset and Death |
| and. | /Medical Examiner | | resulting in death) | Due to (or as a cons | sequence of). | 1 | N | W W | | 1/- |
| | Lammer | er | Sequentially list conditions, b. | Due to (or as a cons | | Lrtery | Discase | | | years |
| | outed id ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | |
| ó, | icate be executed physician and s the burial-transit | l Exa | resulting in death) Last | Due to (or as a cons | sequence of): | | | | | |
| 8760, | icate b physic the b | dical | d. | | | | | | | |
| 9 xo | eath certific attending p for use as | n/Me | IF FEMALE: 23b. Was decedent pregnant | c. If yes, outcome of pre | gnancy | | | | 23d. Date of de | livery |
| P.O. Box | e death | Completed by Physician/Me | in the past 12 months? 1 ☐Yes 2 ☐ No | 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown | | ☐ Ectopic pregnand ☐ Other <i>(specify)</i> _ | су | | Month | Day Year |
| <u> </u> | that the de ned by the a detached t | Phy | 9 ☐ Unknown Part II. Other significant conditions cont | | resulting in the I | ınderlying cause giv | ven in Part I | 23e. Did tohacco | use contribute to | the cause of death? |
| ds, | iw requires that s been signed k s should be deta | d by | Cangestire He | art Failure | Tooding III alo | indonying daddo gi | voir are a | 1 □ Yes | | robably 4 Unknown |
| CO | aw req | olete | Diabetes Mell | tes | | 11/2 | | 24a. Was an | 24b. Were au | utopsy findings available |
| <u> </u> | The la | Com | | | | | | autopsy performed? | death? | completion of cause of 2 □ No |
| Vita | sician: The law s certificate has b irector, page 2 s | Be (| 25. Was case referred to medical examiner? | ospital: | | | 26. Place of Death (| | | |
| ð | ding Phys). After this funeral dir | To : | 1 Yes 2 No Ho 27. Manner of Death | 12 Inpatient 2 | 28b. Time of | III 3 LI DOA | | e 5 Residence | | ecify) |
| ion | ath. r: Afte | atior | 1 Natural 5 □ Pending 2 □ Accident investigation | (Month, Day, Yea | r) Injury | Woi | rḱ?]Yes 2 □ No | | ,, | |
| Division of Vital Records, | I or Atte after de Directo i in by th | Certification: To | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - A building, etc. (Sp | At home, farm, st | reet, factory, office | 28 | Bf. Location (Street City or Town, Sta | and Number or R ate) | ural Route Number, |
| | To the Hospital or Attending Physician: The law requires that the death certifinin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical C | 29a. Certifier (Check only one) 1 CertifyIng Phys 2 Medical Examin | cian: To the best of my er: On the basis of exar and manner stated | knowledge, dea nination and/or i | th occurred at the t nvestigation, in my | time, date and place, an opinion, death occurre | nd due to the cause d at the time, date a | e(s) and manner a and place, and due | s stated. e to the cause(s) |
| | To the within To the compl | Me | 29b. Signature and title of certifier | 2 | ~ | 29c. Licen | se number | 29d. [| Date signed (Mon | th, Day, Year) |
| | / | | Muntings 16 | ands | | D5 | 5427 | Au | 94st 30 | 0,2008 |
| | 14 | | 30. Name and address of person who cor | npleted cause of death | (Item 23a) (Type | Print) | 5427 St. SAlis | 1 | | 6-0-7 |
| | Sta | te. | 31. Date filed (Month, Day, Year) | 32. Registrar's S | <i>100とし</i> ignature | HICIULL | >1. 2Hlis | spuny r | 11d 21 | 801 |
| | Registr | | SFP 0 5 200 | 6 | | act, | | | | |
| DHI | MH 17 Rev 1/2 | 001 | 327 V J 200 | Jan Marie | Je John | 35 | | | | |

| | - | For State Registrar | Otato of mai | y ranta r | Certi | ficate of | Death | | Reg. No | 2008 | 28545 |
|--|-------------------|---|--|-----------------|--------------------------|--|---|--|---------------------------|---|--|
| Physiciar /Medica | _ | 1. Decedent's Name (First, Middle, La | MILDREI |) | TYD | INGS | | 2. Date of AMonth | Death | y živ | 3. Time of Death 855 M |
| Examine | | 4a. Facility Name (If not institution, give the COUNTY) 5. Social Security Number 6. Second Security Number | GENERAL | | PITAL | b. City, Town, o | Location of D | BIA | | County of Death | |
| Funeral Director | | | sex 7. Age 1 □ M 2 ĎF | (In yrs. last b | | Months Days | | Min. (Month | Day, Year, | Cot | yland |
| leath with the Maryland ns 23a or 28a-f show | | 10a. State 10b. County Maryland Howard | | 10c. City, To | wn or Local | city | | | | | 10d. Inside City Limits 1 ☐ Yes 2 █️No |
| h with the | 5 | 10e. Street and Number 12100 Triadelphi | a Road | | | 10f. Zip Code | L042 | | 10g. C | itizen of What Cou USA | , |
| or Iter | p | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: | er in U.S. | | s Decedent of Fes, specify Cub | lispanic Origin an, Mexican, P Specify: | n? (Specify Yes o Puerto Rican, etc. | No- | 14. Race - Amer Black, White Specify: | |
| permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", any injury or other traumatic event, its Modical Exponce. | Completed | 15. Decedent's E (Specify only highest gr. | ducation ade completed) College (1-4or 5+) | 1 | (Give kir life. DC | nt's Usual Occup nd of work done NOT use retire Onnel N | during most of | | 16b. ł | Kind of Business/i | ndustry Governmen |
| id be filed lental Hyg ked other Ic event, | o pe | 17. Father's Name (First, Middle, Last Herman Gr | oh | | | | 18. Mother's | Name (First, Mic | | | |
| 2 shou and N is mar | | 19a. Informant's Name/Relationship | | | | | | | | or Town, State, Z | • • |
| 1 and Health em 27 ther tr | | Scott Tydings - 20a. Method of Disposition | son | | | | | Date | | City, MD Location - City or | |
| Pages tment of tant: If it | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | | | Haven | on (Name of tory or other place Cemete | ry Se | | | len Burn | |
| permit Depar Impor any In | | 21. Signature of Funeral Service Lige | Holler | | 31 | | ain Rd | ., Pasac | lena, | neral Ho MD 21122 | |
| Physician | | 23a. P. v. 1. Enter the disea e, or constitute, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | plications that cause one cause on each line a. | | | | | | ry arrest, | | Approximate Interval Between Onset and Death |
| /Medical Examiner | | Sequentially list conditions, if any leading to immediate | b. RENAL Due to (or as a | FAI | LUR | E | | | | | DAYS |
| ing physician and as the burlal-transit | Examme | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. BACTER Due to (or as a | | 11A FUNGEMIA uence of): | | | | | | DAYS |
| rtificate be ng physicia as the bur | agical | | d. HYPU | NAT | REM | IA | | _ | | | DAYS |
| attend for us | P.II ysiciali/ime | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown | ☐ Fetal dea | | ctopic pregnand other (specify) _ | ey | | _ | 23d. Date of deli Month | ivery Day Year |
| v requires that the d | 2 | Part II. Other significant conditions | contributing to death but | not resulting | in the unde | erlying cause giv | ren in Part I. | | | | the cause of death? obabły 4 ☐ Unknown |
| has bee | Collibrated | PANCYTOPE | NIA | | | | | <u> —</u> | Vas an iutopsy | prior to d | topsy findings available completion of cause of |
| sician: The law certific te has rector, page 2 a | | DI ABETES A 25. Was case referred to medical | NELLITUS | | | | 00 Pl | 1 □ Ý | | death? | 2 No |
| yslcia is cert directo | ۵ | examiner? | Hospital: | 2 ER/0 | Outpatient | 3 □ DOA Oth | or. | f Death <i>(Check o</i> ing Home 5□ I | | 6 ☐ Other (Spec | cifv) |
| Ital or Attending Physician: The Irs after death. al Director: After this certificate he led in by the funeral director, gage | ation: | 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigatio | 28a. Date of Injury (Month, Day, | Year) 28b | . Time of Injury | 28c. Inju Wor M 1 | | 28d. Descr | | ury occurred | |
| al or Atte |) Line | 3 Suicide 6 Could not be determined | | | farm, stree | t, factory, office | | | on (Street a Town, Sta | | ıral Route Number, |
| | Medical | | hysician: To the best of miner: On the basis of e and manner state | examination | | | | | | | |
| To th withir To th comp | INC. | 29b. Signature and title of certifier | PHYS | ALIX | N | 29c. Licens | se number | | 29d. D | ate signed (Monti | ı, Day, Year) |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

AA-, JACUSUN BOOTH 5755 CEDAR LANE, COLUMBIA, MD 21044

TA-GAYJACKSON BOOTH

D005212Z

28,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Shokooh Taghinia 2008 9:55 P M August 31, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, February 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 🗓 F Months Days Hours Country) Iran 81 1927 214-06-2636 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Montgomery Rockville death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 230 West Edmonston Road 20852 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White à 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Soltan Sanatian Ali Sanatian ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is in any Injury or other traum once. Shahram Taghinia/Son 9119 Redwood Avenue, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service_Licenses M01498 dog 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cardiac Pulmonary Arrest 10 minutes /Medical Due to (or as a consequence of): Examiner Severe Aortic Stenosis Sequentially list conditions, if any, leading to huminediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off: The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 🙀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 (3tNo Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065505 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cienter Dr. Rockville. QIUFANG CHENG 9901 medical 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ^{Day} 2008 **Physician** 28. 10:30 A M Alice Н. Tavlor Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Towson Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Sta Months | Days | Hours | Min. | Sept. 16, 1928 | Mary Tand 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F 79 Yrs Director 220-24-5300 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maryland Eventure Trust the martine and 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Towson Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 509 E. Joppa Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electronic Electronic Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice E. Zeigler Alice H. Howard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Towson, Maryland 21286 509 E. Joppa Road Kenneth M. W. Taylor/Husband 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Hilltop Service Corp. 9/4/08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensei Ruck Towson Funeral Home, 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tduanced 2 YU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the buriel-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. F 1 ☐Yes 2 ☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Ā 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Matural 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital o within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 031865 mian-0 K completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 821 N Gutan Street Balt more ma Rm mian-Door 206 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State SEP 05 Registrar

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore

MD

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28550 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 8:20^{P™} Physician Eli Rody Vuicich 2008 September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 12300 Rosslare Ridge Rd., #202 Timonium If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 476-16-4271 86 Director May 26, 1922 Minnesota Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show or other traumatic event, the Medical Examinar must be multipled at 1 ☐ Yes 2 X No Director Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature..." any hilury or other traumatic excessions. U.S.A. 21093 12300 Rosslare Ridge Rd., #202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ways 2 No. If Yes, Give 1943-1946 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 👿 No ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Science/Engineering Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela Price Dan Vuicich ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 Ashley Terrace NW, Washington DC Katherine Schinasi / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Megiorial Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-06-2008 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. lauce 21204 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** SMALL LYMPHOCYTIC LYMPHOME /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HORTIC STENOSIS 2 No 3 Probably 4 Unknown 1 ☐ Yes KNEE INFECTION 24b. Were autopsy findings available prior to completion of cause of death? SEPTIC ARTHRITIS 24a. Was an performe 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation ieral Director: A 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

20+1

30. Name and address of person who comple ERIC J. SEIFTER 31. Date filed (Month, Day, State

29b. Signature and title

0

0755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

ause of death (Item 23a) (Type, Print)

D29373

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) August ANTIGONE. **Physician** 6-25PM WOOD 30 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City Howard Ellicott City Health & Rehab if Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Apr. 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M **XX**F 100 1908 Greece Director 202-20-5449 Usual Residence of Decedent the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1X Yes 2 □ No must be notified Director PA Dauphin Susquehanna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 9 USA 17109 517 Alta Vista Avenue items 23a death v Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ann: If item 27 is marked other than "natural", or ite ury or other fraumatic event, the Medical Examine ury or other fraumatic event, the Medical Examine 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 8 Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Andricopoulos Eleni Maniotif 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
important: If Item 27 is
any injury or other trau
once. 517 Alta Vista Avenue Harrisburg, PA 17109 H. Gloria Hampilos/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
East Harrisburg
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 9/4/2008 Harrisburg, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INPARCTION **Physician** /Medical Due to (or as a consequence of): Examiner BERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2♥No 3 Probably 4 Unknown 1 ☐ Yes Completed OSTEO ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 3 0 46 9 29d. Date signed (Month, Day, Year) September 2nd, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Brint) XWAY # 308 Columbia, MD. 21045 N.B. VELLANKI, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 1 38140.1

Registrar

SEP 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Robert H. Webb 29, 2008 3:10 A August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dundalk I Vear I I Under 24 Hrs. Future Care Northpoint Baltimore Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 **∑M**M 2 □ F Months Hours -1 - 1920217-07-3730 MD 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XIYes 2 □ No Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1914 Wareham Road 21222 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 ☐ No White Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Brooks Webb Nettie Mae Houston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Webb - Wife 1914 Wareham Road, Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 8-30-08 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Lin 2134 Willow Spring Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death THEROSCUEROTIC CARDIOVASCULAR DYJ EAR & Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

the Medical

72 hours after

d 2 should be filed within : th and Mental Hygiene. 7 Is marked other than ":

es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie of Hem 27 Is marked other to other traumatic event, the

Pages 1 Department of Important: If It any Injury or o

Baltimore, Maryland 21215-0036

Box 68760;

P.O.

Division or Vital Records,

Director

Funeral

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Completed

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attending physician and for use as the burial-trar

Examiner Physician/Medical signed by the a d be detached f þ Completed certificate has birector, page 2 s Be P this Certification:

certificate be executed To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23h Was decedent pregnant in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes performed 2□ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☐ Natural 28a. Date of Injury 28h Time of 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifié and manner stated. 29c. License number 29b. Sid nature and title of certific 29d. Date signed (Month, Day, Year) D0060560

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day, Year)

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RIVER MECK 4 H 109

eted cause of death (Item 23a) (Type, Print)

BACK

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2008 28553 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Florence A. Weir 2008 Sept. 8:58 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockspring Village Forest Hill Harford Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 100 Dec. 10,1907 Illinois 218-26-4115 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Marylar feath and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, it is Medical Exarther must be notified at Director 1 TarYes 2 □ No Petersburg Virginia Petersburg 10e. Street and Number 10g. Citizen of What Country? Funeral 1325 Concord Drive 23803-4617 United States Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√TNo Specify. þ Specify: 3€ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harvey Crawmer Edith L. Rowe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If Item 27 is any injury or other trau Mr. George Weir (Son) 2307 Tuchahoe Road Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 9/5/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Heart Coronary District /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off Physician: The law requires that the death certificate be executed -tran and physician a s the burial-Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) □Yes Ö the 9 Unknown signed by to 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed page certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Activity Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. nours after death neral Director: / filled in by the fi 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Medical 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 10 9/3/2008 Do 059387 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD 2 Colgale Forest Hill Aly Naguib, MD Dr. 2008 Registar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5, perFH, G883, 9/26/08, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 9:15 PM Williams 2008 0 Deptember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmare Year If Under 24 Hrs. NIA HTICKEY 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 6. Sex **Funeral** -82=5588 Hours Months Days 1 M 2 □ F North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Nes 2 No Director NIA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 2121 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: Specify: Black 2 3 ☐ Widowed 4 ☐ Oivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) H.A.B. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Ira. Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore lumbe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Williams ٥ Dell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williams Rd Valley Brother MD 21236 116 terstown 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 9/4/08 Memorial KandallStown 4 ☐ Donation 5 ☐ Other (Specify) Hark permit. 22. Name and Address of Facility 21. Synature of Funeral Service Licensee Home Funeral towell Ba Himore MD ZIZG7 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records. 4 Unknown 3 Probably 1 🗌 Yes 2 No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was ar certificate has autopsy performe Yes 24 1 ☐ Yes 2 ☐ No 1 ☐ Yes Vital To the Hospital or Attending hysician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only only examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) detern 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) onth, Day, Year) 0 29b. Signature and title of certi e and address of person who com (Vear) Registrar's Signa 31. Date filed (Month, Day) State 2008 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 28555 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 2, 2008 **Physician** 11:59 AM GARY PROCTOR WARFIELD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1949 Min. 1**X** M 2□ F Months Days Hours Mary Land 58 218-54-0005 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nd other than "natural", or items 23a or 28a-f show event, the Medical Examinations to notified at 1 ☐ Yes 2 No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 USA 402 Kennard Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2X No Specify: δ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public Education Assistant Principal Department of Health and Mental Hygis important: if Item 27 is marked other any injury or other traumatic event, If once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll Wilbur Warfield Catherine Louise Proctor ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma M. Warfield / Wife 402 Kennard Ave., Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn 9-8-08 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. <u> Cokesbury Road, Abingdon, MD 21009</u> 23a. Part 1. Enter the disease, or comshock, or heart failure. List do blioctions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** ARDS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last MEUMBALG Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 disease Chronic interstitial luna 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 🖽 No 2 1No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

P.O. Box 68760 Records, Division of Vital within 24 ho

To the Fune

completely f

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

asin klein

Mara

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

00063420

29d. Date signed (Month, Day, Year)

apeake Drive Bel Ar, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** LORRAINE ALYSE WALTER 2008 otember 2 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) If Under If Under 1 Year Social Security Number **Funeral** Year) Days Hours 1 □ M 2 🔀 F 3, New York 215-34-2080 72 1936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ∏Yes 2 No injury or other traumatic event, the Medical Examinar must be notified Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 21236 or items 23a 4439 Ebenezer Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2√2 No Specify: ģ White 3 Widowed 4 Divorced "natural" A 10 C VOQ 17 Maryland 21215-00 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk State Government 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Amanda Cooper Ward (nmn) Welling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4439 Ebenezer Rd., Baltimore, Maryland 21236 James C. Walter / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Fallston, Maryland Highview Memorial Gdn 9-8-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Ě A. Weber C athlien 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ue to a as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Exami and be exec Due to (or as a consequence of): Box 68760. ttending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No the detached Ö 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. 1 ☐ Yes 2 🚺 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28b. Time of Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Many fer of Death 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death.
To the Funeral Director; After it completely filled in by the funeral 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FISHER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28557 State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month 10:00 AM WATERS 2008 LAURA 3 SEPTEMBER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CAROL COUNTY SYKESVILLE TRANSITIONS HEALTH CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours 1□M 2XF Months June 7, 093-40-5433 61 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 21 No Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5014 Round Tower Place 21044 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2M No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Tutor/Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Darthea Douglis George Purvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5014 Round Tower Place, Columbia, MD 21044 Robert W. Waters, III - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 09/4/2008 Glen Burnie, MD Atlantic Crematory, * 4 ☐ Donation 5 ☐ Other (Specify) Inc 21. Signature of Huneral Service Licensee 22. Name and Address of Facility.
Witzke Funeral Home, Inc.

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral', or Items 23a or 28a-f show Examiner must be notified at

"natural"

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event ONCB.

or other traumatic event,

Be Completed by Funeral Director

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ysician and e burial-transit use as the signed by the a page 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

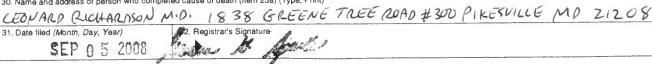
| 4 | > VIEDECSE | CX SC MU128 | 5555 T | win Knolls Ro | oad, Columb | oia, MD 2 | 21045 |
|---|---|--|--|---|---|---|---|
| | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the death. D | o not enter the mod | e of dying, such as cardiac | or respiratory arrest, | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a consequence | | ISM OF BRI | 111 | | |
| iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b | ce of): | | | | |
| icai Exan | that initiated events resulting in death) Last | Due to (or as a consequence d. | ce of): | | | | |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 monuts? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown | ath 3 □Ectopic pi | | | 23d. Date of del Month | ivery Day Year |
| ed by Ph | Part II. Other significent conditions of | contributing to death but not resulting | g in the underlying o | ause given in Part I. | 23e. Did tobacco | | the cause of death? |
| omplet | | | | | 24a. Was an autopsy performed? | prior to death? | utopsy findings available completion of cause of 2 No |
| Be C | 25. Was case referred to medical | | | 26. Place of Deat | h (Check only one) | | |
| To B | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatient 2 ER | Outpatient 3 DC | Other: 4 Nursing Ho | ome 5 Residence | 6 ☐Other (Spe | cify) |
| | 27. Manner of Death 1 Matural 5 Pending 2 Accident investigatio | 28a. Date of Injury (Month, Day Year) 28 | b. Time of 2 Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how in | jury occurred | |
| Medical Certification: | 3 Suicide 6 Could not be determined | | , farm, street, factor | y, office | 28f. Location (Street City or Town, Sta | and Number or Ru ate) | ıral Route Number, |
| edicai (| 29a. Certifier 1 Certifying Pt (Check only one) | nysician: To the best of my knowle miner: On the basis of examination and manner stated. | dge, death occurred and/or investigation | at the time, date and place, i, in my opinion, death occur | and due to the cause red at the time, date a | (s) and manner as and place, and due | s stated. to the cause(s) |
| Me | 29b. Signature and title of pertifier | // | | c. License number | | Pate signed (Mont | h, Day, Year) 2 3 2008 |

D57722

State Registrar

31. Date filed (Month, Day, Year) SEP 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** tudre. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospic Christ enter altimore If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) Hours Min. 1 ☐ M 2 🛛 F 24 Months Days 218-14-0572 9 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10h County ns 23a or 28a-f show must be notified at 1 □Yes 2 No Funeral Director Forest 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Examiner must) once. 21050 nited 207 Montgomer 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: ۵ 3 ☑ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 omemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen မ han wald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard 20b. Place of Disposition (Name of cemetery, crematory or other place) torest Hill MD 21050 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Baltimore, MD Dept 5, 2008 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cometers 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkuilk
8800 Harford Road Parkuille mb 21234 21. Signature of Funeral Service Licensee autin Approximate Interval Between Onset and Peath 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifie 🖅 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature apd

State Registrar 31. Date filed (Month.

3

UDREG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMW J. CHAWKIG W 6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 22, 2008 РМ William Lewis Asmussen, Jr. 4:10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 ☑ M 2 ☐ F 68 Yrs Maryland 217-32-4906 October 6, 1939 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21284 20653 Lexwood Court Apt. 14A IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify: 3₺ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Lewis Asmussen, Sr. Bessie Viola Windsor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 44450 Tall Timbers Road Tall Timbers, MD 20690 Cindy Marie Asmussen / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State September 2, Maryland Veteran's Cemetery Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 2008 of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 WITH RESPIRATORY

LAND 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. HYPOXIC Immediate Cause (Final disease or condition resulting in death) BRAIN INdury CHRONIC OBSTRUCTIVE XACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

/Medical **Examiner** P.O. Box 68760 Records, **Division of Vital**

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit certificate funeral director, After this Attending al or Attendation are after death.

eral Director: A'
iv filled in by the ' To the Hospital within 24 hours a

Physician

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Director

item 27 is marked other than "natural" or items 23a or 28a-f shot other traumatic event, the World's Examinating the notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23

permit. Pages 1 and 2 s Department of Heath a Important: If item 27 is any Injury or other trau once.

Physician

Baltimore, Maryland 21215-0036

the Maryland

Registra

31. Date filed (Month, Day, Year) AUG 2 5 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00051738

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Aldon Joseph Blubaugh, Jr. 17, 2008 1845 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany WMHS-Braddock Campus Cumberland If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 □ F Months 74 07/13/1934 Maryland Director 216-30-1807 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notifiled at 1 Tyyes 2 No MD Allegany Cumberland Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 430 Pine Place 21502 Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: ↑ 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ No Specify: 3altimore, Maryland 21215-0036 Specify: White ⋧ 3 □ Widowed 4 □ Divorced WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Iron Worker Union other t other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 ment of Health and Mental I ant: If Item 27 is marked o Aldon Blubaugh, Sr. Blanche Williams Joseph ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 430 Pine Place, Cumberland, MD 21502 Nora I. Blubaugh / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet Cem @ Rocky Gap 08/21/2008 4 Donation 5 Dother (Specify) Flintstone, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 2 No 1 ☐ Yes certificate To the Hospital or Attending Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

nes State

Registrar

3+

31. Date filed (Month, Day, Year) AUG 1 9 2008

29b. Signature and title of certifier

Shiv C. Khanna, M.D., 2. Registrar's Signature

30. Name and odress of mison who completed conse of death (Item 23a) (Type, Print)

Berso.

29c. License number

D0054004

1221 National Highway, LaVale, Maryland

29d. Date signed (Month, Day, Year)

August 18, 2008

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 2

| | | | 1 - State Registrar | | (| Certificate | of Deat | h | Reg. | No. | UO | 200 | 0 1 |
|----------------|--|-------------------|---|---|----------------------|--------------------------------------|---------------------------|-------------------------------------|-----------------------------|-----------------------|-------------------|------------------------------------|----------|
| | | | 1. Decedent's Name (First, Middle, L | ast) | | | ., | | te of Death | | Voor | 3. Time of [| Death |
| | Physici /Medio | | Dale Jeffrey Baker | | | | | 08 | nth B | Day 12 20 | Year 008 | 1440 | М |
| 1 | Examir | | 4a. Facility Name (If not institution, g | ive street and number) | | 4b. City, To | wn, or Locatio | n of Death | | 4c. County | of Death | | |
| - | | ۲. | WMHS-BRADDOCK C | AMPUS | | | BERLAND | | | ALLE | GANY | | |
| | Funeral | | 5. Social Security Number 6. | Sex 7. Age | (In yrs. last birth | Months F | Year If Und Days Hours | er 24 Hrs. 8. Dat Min. (Mo | e of Birth onth, Day, Ye | ear) | 9. Birthp Cour | olace (State or ntry) | Foreign |
| | Director | | 217-42-6786 | 7 | 64 | rs. | | Nove | mber 25, | 1943 | Mary | yland | |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | | 1 | 0d. Inside City | y Limits |
| | Maryl f sho | jo | Mandand Alland | | Frostbur | - | | | | | | 1 Tes | 2 No |
| | the 28a | rec | Maryland Allege 10e. Street and Number | | LIOSUUL | 10f. Zip Co | ode | | 10g. | . Citizen of V | What Cour | ntry? | • |
| | 3a or | 0 | 37 Mis | ty Lane | | 0150 | • | | | .S.A. | | | |
| | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Madical Evanting runst be notified at | Funeral Director | 11. Marital Status | 12. Was Decedent E | ver in U.S. | 2153 13. Was Deceden | t of Hispanic | Origin? (Specify Ye | s or No- | 14. Rac | | can Indian, | |
| 9 | or ite | F | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 N | 0 | | | can, Puerto Rican, | etc.) | | ck, White, | etc. | |
| 8 | ral", c | d by | 3 Widowed 4 Divorced | If Yes, Give T Year or Dates: | | 1 ☐ Yes 2 | No Speci | ry: | | Specify | Whit | te | |
| 21215-0036 | 72 h | Completed | 15. Decedent's E (Specify only highest g | Education rade completed) | 16a. I | Decedent's Usual C | Occupation | ost of working | 161 | o. Kind of Bu | usiness/In | dustry | |
| 2 | ithin ne. han " | ğ. | Elementary/Secondary (0-12) | College (1-4or 5+ | .) | life. DO NOT use i | retired) | oot of Morning | | | | | |
| | ed w lygiei her tl | | 9 | 0 | 108 | der operator | 1 | | | oal mini | | | |
| Maryland | ould be filed w Mental Hygie larked other t | Be | 17. Father's Name (First, Middle, Las | it) | | | | ther's Name (First, | Middle, Mai | den Surnam | ie) | | |
| <u>~</u> | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Its M. | မ | Carl Baker | | 1 | | | ith Haupt | | | | | |
| a N | 12 st th an 7 is n traun | | 19a. Informant's Name/Relationship | | | | treet and Nun | nber or Rural Route | | | | | |
| | 1 and 2 Health em 27 i | | Sheila Baker 20a. Method of Disposition | wife | | Misty Lane | of ! | Frostburg Date | | Mary c. Location - | | 21532- | - |
| کّ | permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. | | 1 Burial 2 ☐ Cremation 3 | | | Disposition (Name crematory or othe | i | | | | | | |
| Baltimore, | rt. Part rtant rtant | | 4 □ Donation 5 □ Other (Spec | | Blo | cher Cemeter | <u> </u> | August 15, 2 | 008 A | vilton | Ma | ryland | |
| Ba | permit. Departn Importa any Inju | | 21. Signature of Funeral Service Lice | ensee | | 22. Name and A | | • | A E- | 41 | MD / | 11622 | |
| | | | 23a. Part 1. Enter the disease, or cor | Jordan Hart | the death. De se | | | me, 57 Frost | | | , MD 4 | Approximate | |
| | | | shock, or heart failure. List only | y one cause on each line | Ð. | | | - | ratory arrest | , | | Interval Betw Onset and D | veen |
| - | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. TANCK | FATC | C CAI | VCEL | | | | | MO | WII |
| 100 | Examiner | | | Due to (or as a | consequence of |): | | | | | | | |
| | | - | Sequentially list conditions, | b. Due to (or an a | consequence of | | | | | | | | |
| | rted nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequence of | , | | | | | | | |
| | ficate be executed physician and s the burial-transit | xar | that initiated events resulting in death) Last | c Due to (or as a | consequence of |); | | | | | + | | |
| 9 | siciar buri | | | | _ `_ ` | | | | | | | | |
| 68760, | ficate phys the | Medical | | d | | | | | | | | | |
| Box | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of | of pregnancy | | | | | 23d Dat | te of delive | env | |
| ŏ | death cer attendin for use | Physician | in the past 12 months? | 1 ☐ Live birth 2 4 ☐ Pregnant at | | 3 ☐ Ectopic preg 5 ☐ Other (speci | | | | | onth | | ear |
| o. | that the de ned by the detached | ysi | 9 Unknown | 9 Unknown | | | .,, | | | | | | |
| о. С | s that ned to deta | | Part II. Other significant conditions | contributing to death but | t not resulting in t | he underlying caus | se given in Par | t I. 23 | e. Did tobac | co use cont | ribute to th | he cause of de | eath? |
| Vital Records, | quires n sign ald be | ρ D | | | | | | | 1 🗌 Yes | 2 🗆 No | 3 ☐ Prot | bably 4 🗹 Ú | Inknown |
| ၀ွ | w requir s been s should | Completed by | | | | | | 24 | a. Was an | 24b. 1 | Were auto | posv findings a | vailable |
| æ | The lav | Ĕ | | | | | | | autopsy performed | 1?/ | death? | ppsy findings a impletion of ca | iuse of |
| ta | Iclan: Th certificate ector, pag | | 25. Was case referred to medical | Т | | | 26 Die | | Yes 2 | Mo | 1 □Yes | 2 1No | |
| > | Physician: r this certificaral director, p | o Be | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | t 2 D EB/Outs | eatient 3 DOA | Othor: | ce of Death (Chec Nursing Home 5 | | - 0 00 | | 6.3 | |
| | ding Phy h. After thi funeral c | Ě | 27. Mannard Death | 28a. Date of Injury | y 28b. Tir | | Injury at Work? | | escribe how i | | | (1)/ | |
| Division | Attending or death. ector: After by the fune | ţį | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | (<i>Month, Day</i> , | Year) Inj | ury M | Work? 1 ☐ Yes 2 l | □No | | | | | |
| VIS. | I or Attendi after death. I Director: A d in by the fu | iţi | 3 ☐ Suicide 6 ☐ Could not! | 28e. Place of injur | ry - At home, farn | n, street, factory, of | fice | | | | er or Rura | al Route Numb | ber, |
| ă | al or | Certification: To | 4 ☐ Homicide determined | building, etc. | (Specity) | | | City | y or Town, S | State) | | | |
| | psplt hours inera y fille | | 29a. Certifier 1 Certifying P | hysiclan: To the best o | f my knowledge, | death occurred at | the time, date | and place, and du | e to the caus | se(s) and m | anner as s | stated. | |
| | To the Hospital or within 24 hours after To the Funeral Directory completely filled in the total or the total | Medical | (Check only 2 Medical Exa | mlner: On the basis of and manner stat | examination and ed. | or investigation, in | my opinion, d | leath occurred at th | ne time, date | and place, | and due to | o the cause(s) | |
| | To the common of | ž | 29b. Signature and title of certifier | | // | 29c. L | icense numbe | r | 29d. | Date signe | d (Month, | Day, Year) | |
| | 23 | | 1 | 2 1 | fan. | 2 D | 0054 | 1004 | | 08/ | 13/ | 28. | |
| | , 6 | | 30. Name and address of person who | completed cause of de | ath (Item 23a) (T | | | | | ı | | | |
| | | | | hanna | 1221-6 | Natio. | nal Hi | wy Lav | iale, r | no 2 | 1507 | | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar | r's Signature | | | | | | | | |
| | Registr | ar | AUG 1 5 | 2008 | W | 1. 4 | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 ear 4:45 P August 16, 10v 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 8708 First Avenue, Apt. 504 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/16/1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months 1**X** M 2□ F 87 Egypt 579-56-3065 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20910 8708 First Avenue, Apt. 504 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 X Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Negrine Mattatia Battino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Silver Spring, MD 20910 8708 First Avenue, #504 Elisabeth Battino-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3X Removal from State King David Meml Gdn | 08/18/2008 Falls Church, VA * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21 Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) pertensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 1 🗌 Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

10a. State

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It e Madical Examinar must be notified at

and Mental Hygiene.

item 27 i

permit. Pages I
Department of P
Important: If ite
any injury or ott

Examiner The law requires that the death certificate be executed

use as the burial-transit the attending physician Completed by Physician/Medical ŏ detached s been signed by the should be detached certificate has been page 2 Certification: To Be this s after death. completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

within 24 hours a To the Hospital

Medical

IF FFMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

25. Was case referred to medical examiner? 1∑Yes 2☐No 27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 2 Accident 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50V1 arro 31. Date filed (Month, Day, Year) AUG 2 1 2008

32 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28e-f, perME, 2883, 9/11/08, TT

State of Maryland Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician $\boldsymbol{A}^{\mathsf{M}}$ Lois Donnally Britt 9:06 24 2008 /Medical August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/27/1929 Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2X F 78 West Virginia Director 232-32-2590 Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√∑ No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42036 Clover Hill Ct. 20636 Examiner must Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Mamied 1 Tes 2XXNo If Yes, Give Year or Dates: 'natural', or 1 ☐ Yes XX No Specify: White ð 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the U.S. Government 12 Information Systems Scheduler Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Ellen Clingman Greenleaf Whittier Donally 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If Item 27 is any injury or other trauouce. Randy Britt / Son 42036 Clover Hill Ct. Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carolinia Memorial Gar 8/28/2008 North Charleston, SC. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons MO1206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, backing to immodute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trai Due to (or as a physician Physician/Medical attending for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a∏IJnknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 2□ No P 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 9.23-08 2 Accident 0430 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 42036 Clover Hill 4 Homicide Ct. Hollywood, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

Records, P.O. Vital Division or

certificate be executed

Box 68760

within 72 hours after death

Baltimore, Maryland 21215-0036

certificate has After this the Hospital or Attending within 24 hours after death To the Funeral Director:

> State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

AUG 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14285

29d. Date signed (Month, Day, Year)

25365 Point Lookout Road Leonardtown, Maryland 20650

| | | | For State Registrar | State | e of Ma | ıryland | • | rtment c rtificate d | | | /lental Hy | | e .200 | 8 | 285 | 54 |
|-------------|---|------------------|---|--|--|---|-----------------------------|---|--------------------------------|------------------------------|------------------------------------|------------------------|--------------------------------------|--------------------|---|------------|
| | Dhoriei | | 1. Decedent's Name (First, Mic | Idle, Last) | | | | | | | 2. Date of D | | | Ĭ | 3. Time of Dea | th . |
| | Physici /Medio | | KENNETH | | | BROW | N | | | | AUGUS | | | | 1:30 F | , M |
| 1 | Examin | er | 4a. Facility Name (If not institut 8500 MIKE SF | | | 206 | | 4b. City, Tow CLIN | | ion of Death | | 4c | PRINCE | eath GE | ROGE'S | |
| Ī | Funeral Director | | 5. Social Security Number 579–52–9508 | 6. Sex 1 ★ M 2 □ | - | (In yrs. las | t birthday) Yrs. | If Under 1 Ye Months Da | ear If Un | ider 24 Hrs. Irs Min. | 8. Date of B (Month, D | ay, Year) |) | Counti | | |
| | ס | | Usual Residence of Decedent | | | | | | | | JUNE (|) 194 | +3 W.F. | 1911 | NGTON, I | |
| | show | 5 | MD PRIM | ^{ty} ICE GEROG | r i c | 10c. City, 1 | | cation | | | | | | 10 | d. Inside City Li 1X□Yes 2□ | |
| | 28a-f | rect | 10e. Street and Number | CE GERUG | ES | CL1. | NTON | 10f. Zip Coo | de | | | 10a Ci | itizen of What | Count | | 1110 |
| | 23a or | Funeral Director | 8500 MIKE SE | IAPIRO DR | IVE # | 206 | | | 735 | | | USA | | | , | |
| 15-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Model Expiration must be indiffed at | þ | 11. Marital Status 1 ☐ Never Married 2 🔀 M 3 ☐ Widowed 4 ☐ Divorce | Arme 1 ☐ Y If Yes | Decedent End Forces? Yes 2 1 No., Give or Dates: | | | Vas Decedent fYes, specify (□Yes 2☑ | | | ecify Yes or N Rican, etc.) | 0- | 14. Race - A Black, W Specify: | hite, et | | |
| ה ה | n 72 h | Completed | 15. Deced (Specify only high | ent's Education nest grade comple | ted) | | 16a. Deced | lent's Usual Oo kind of work do OO NOT use re | ccupation one during i | most of work | ing | 16b. K | Kind of Busine | ss/Indu | ıstry | |
| 7 7 | filed within Hygiene. other than' ent, the M | mo | Elementary/Secondary (0-12 11th |) Colle | ge (1-4or 5- | +) | | STRUCT | | | | | PRIVAT | Ε | | |
| yland | tat Hygid d other event, III | Be C | 17. Father's Name (First, Middl | e, Last) | | | | | 1 | | e (First, Middle | e, Maider | n Surname) | | | |
| yla | 2 should be and Menta is marked aumatic ev | ပ္ | UNKNOWN | | | | | | | LORIA | | | | | | |
| 20 | id 2 st Ith and 27 is n traun | | 19a. Informant's Name/Relatio TANYA BROWN / | | | | | | | | al Route Num | | | | Code) | |
| ē, | s 1 and of Health Item 27 other to | | 20a. Method of Disposition | | | 20b. Plac | | Sition (Name of atory or other | | | VASHING Date | | ocation - City | | n, State | |
| E | Page ment c ant: If ury or | | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other | n 3 □ Removal f (Specffy) | rom State | 1 | | e Crema | | 8/25/ | 2008 | Riv | erdale | ,Ma | ryland | |
| рани | permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once. | | 21. Signature of Funeral Service | e Licensee | _ | <u>'</u> | | | | - | B. JE LANDOV | | | | | |
| | | C | Part 1. Enter the disease, | or complications to | nat caused | the death. | | | | | | | | - | Approximate Interval Between | |
| 1 | Physician | | shock, or heart failure. Li Immediate Cause (Final disease or condition | | | | ARY A | RREST | | | | | | 1 | Onset and Deat | h h |
| | /Medical Examiner | | resulting in death) | | | consequer | - | | | | | | | | | |
| | | ē | Sequentially list conditions, | D | | ARTE | | SEASE | | | | | | - | | |
| | cuted nd ranslt | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | S MELL | | | | | | | | | | |
| Š | icate be executed physician and the burial-transit | I Ex | resulting in death) Last | Du | a to (or as a | consequer | nce of): | • | | | | | - | | | |
| | | dical | | d | | | | | | | | | | - | | |
| O. DOX | To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1 Yes 2 No 9 Unknown | 1 1 4 0 | ive birth | of pregnanc 2 Fetal de time of dea | eath 3 | Ectopic pregr Other (specif | | | | | 23d. Date of Month | | ry Day Year | |
| , L | s that gned b e deta | by Pt | Part II. Other significant condi | | | | ng in the ur | derlying cause | given in Pa | art I. | 23e. Did | tobacco | use contribute | to the | cause of death | 1? |
| cords, | equire | ted t | PERIPHERAL | VASCULAI | R DISE | EASE_ | | | | | 1 🗆 | Yes 2 | X No 3□ | Proba | ibly 4 ☐ Unkr | iown |
| ב ב ב | The law rate has boage 2 sh | Completed | | | | | | | | | 24a. Wa auto perl 1 □ Yes | POSV | 24b. Were prior death | 1? | sy findings avai pletion of cause 2 (X)No | able of |
| 8 | ding Physician: The h. h. After this certificate h. funeral director, page | BeC | 25. Was case referred to medic examiner? | | | | | | 26. P | lace of Deat | n (Check only | | 0 101 | es i | 2 123140 | |
| 5 | Physical direction | ဥ | 1 XYes 2 No 27. Manner of Death | | | | | 1 3 DOW | | Nursing Ho | me 5 Res | | | pecify |) | |
| 5 | ttending death. tor: After the funer | ation | 1 XNatural 5 Pend 2 Accident inves | ling (stigation | Date of Injur Month, Day | ; Year) | Bb. Time of Injury | | Injury at Work? 1 ∐Yes 2 | 2 □No | 28d. Describe | now inju | iry occurred | | | |
| 2 | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo | Certification: | 3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete | d not be rmined 28e. P | Place of Inju building, etc. | ry - At home . <i>(Specify)</i> | e, farm, stre | eet, factory, offi | се | | 28f. Location City or To | (Street a. wn, Stat | nd Number or le) | Rural | Route Number, | |
| | To the Hospi within 24 hour To the Funer completely fill | edical | 29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medic | ring Physician: To al Examiner: On t and | the best of the basis of manner state | examination | edge, death n and/or inv | occurred at the estigation, in i | ne time, dat my opinion, | te and place, death occur | and due to the red at the time | e cause(, date an | s) and manne nd place, and o | r as sta due to | ated. the cause(s) | |
| | Vithii withii comp | ğ | 29b. Signature and title of certif | isy . | | | | 29c. Lic | ense numb | er | | 29d. Da | ate signed (Mo | onth, D | lay, Year) | |
| | 12) | | P. SAPHI | > Nu | | | | D53 | 941 | | | AUG | UST 19 | , 2 | 800 | |
| 1 | 20 | | 30. Name and address of person | | | • | | | | | | | | | | |
| | Sta | te | EMMANUEL BRO 31. Date filed (Month, Day, Yea | WN M.D. 4 | 1302_3 32. Registra | r's Signatu | NARAS | KD #_ | R TEM | PLE HI | LLS, M | ARYL | AND_20 | /48 | | |
| | Registr | | AUG 2 5 200 | S Store | الرار | r's Signatu | NO. | | | | | _ | | | | |
| AHC | /H 17 Rev 1/20 | 001 | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 2 per phys, ForDOR,8/28/08,LDB State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 17 per FD, DCR, 8/28/08, LDB Certificate of Death Reg. No. 1. Decedent's Name (First. Middle, Last) 2. Date of Death AUG 16,2008 **Physician** August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** hester bicheste General Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🕶 F Yrs. Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Wes 2 No Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Numb 10f. Zip Code U SA 6 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Jack 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State GOVERNMENT Nurse 17. Father's Name (First, Middle, Last) Matthews 18. Mother's Name (First, Middle, Maiden Surname) Be Mental f Health and Menta Item 27 is marked 2 Y00 homas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drive Temple Hills Dianne S MD. 20748 20a. Method of Disposition Kank ure 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Dity or Town, State permit. Pages 1
Department of It
Important: If Ite
any Injury or ot 1 MBurial 2 □ Cremation 3 □ Removal from State Cometery 4 ☐ Donation 5 ☐ Other (Specify) Veterans HUYlock 22. Name and Address of acility 21. Signature of Funeral Service Licensee Home Henry Funeral 510 washington St. Cam 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** guamous /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Strobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform this certificate 2 ZINo or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of providing moviledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46820 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Hollywood, M.D., 538 Cynwood Drive, St. 2, Easton, MD 21601 State 2008 Registrar

P.0. Division of Vital Records.

| ician | | State Registrar I. Decedent's Name | (Eirn) 18:33: | | - | epartment of I Certificate of | | | eg. No. 200 | 8,28566 |
|--|--|--|--|--|---|--|---|---|--|--|
| dica | | Michae | el David | l Clutz, Sr | | | | Month August | Day 16, 2008 | 7:11 p ^M |
| nineı | | 787 Tren | maine Wa | | | Severn | a Park | | Anne An | undel |
| al or | | Social Security N 219-64-8 Usual Residence of | 766 | . Sex 7. Ao 1 X M 2 □ F | ge (In yrs. last birtl | hday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Dec . 19 | (Year) C | rthplace (State or Foreign Country) aryland |
| | 1 | 0a. State | 10b. County | 7 | 10c. City, Town | | | | | 10d. Inside City Limits |
| once. To Be Completed by Euraral Director | ובנו | MD 0e. Street and Nur | | Arundel | Seven | na Park | | 1 | 0g. Citizen of What C | 1 □Yes 2 🙀 No country? |
| 1000 | ם ב | 787 Trem | maine Wa | Y 12. Was Decedent | EverinIIC | 12 Was Dandort of | 21146 | ooify Voc or No | USA 14. Race - Am | porioso Indian |
| 3 | <u>~</u> | Marital Status Mever Marri Widowed | | Armed Forces | | 13. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 ▼ No | | Rican, etc.) | Specify: W | ite, etc. |
| Completed | | | | grade completed) | | Decedent's Usual Occu (Give kind of work done life. DO NOT use retire | durina most of worki | ing | 16b. Kind of Busines | s/Industry |
| 6 | 5 - | Elementary/Seco | | College (1-4or | 5+) | Truck Dr | iver | | Stroehman | n Bakery |
| To Bo | Ď | 7. Father's Name (| | ist) | | | 18. Mother's Name | e (First, Middle, i .ne Snyd | • | |
| F | | 19a. Informant's Na | ame/Relationship | . ,, | 19b. | Mailing Address (Stree | t and Number or Run | al Route Numbe | r, City or Town, State | |
| | 12 | Rosemary 20a. Method of Disp | | wile | 20b. Place of | 787 Tremain Disposition (Name of y, crematory or other pla | | Date | Park, MD 2 | |
| l | | | Cremation 3 5 ☐ Other (Spe | Removal from State | | y, crematory or other pla tic Cremato | ; Augu: | st 20, | Glen Bur | nie, MD |
| i | | 21. Signature of Eu | meral Service Lie | censee | amo | Barranco de 195 Gov. I | & Sons, P. | A. Sev | erna Park erna Park, | Funeral Home |
| | | hock, or ha | rt failure. List or | omplications that cause lly the cause on each I | d the death. Do n | ot enter the mode of dy | | | | Approximate Interval Between |
| ı | | mediate Couse (iseas condition g in death) | Final n | -a. ANAY | LASTIC | | CYTON | l | | Onset and Death |
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| Evaminer | D | Sequentially list con trany, leading to in- cause. Enter Unde Cause (Disease or | rigitions, rigulate rlying injury | Due to (or as | a esnasquence o | ij. | | | | |
| | LYd | that initiated events resulting in death) I | | c Due to (or as | a consequence o | f): | | | | |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28567 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Emma Elizabeth CONRAD 140M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 83 Director 219-12-1333 20, 1924 Dec. Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 XYes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 145 East North Avenue, Apt. 1E 21740 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces? 1 ∐Yes 2★ No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No \$ Specify. Specify: white 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cook restaurants 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Reed McDonald Margaret Anne Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau once. Richard Shoemaker - son 145 E. North Ave., Apt. 1E, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 8/28/08 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME ψ 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** moni disease or condition resulting in death) 2 /Medical Due to (or as a consequence of): Examiner divm estr. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). cul that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩rknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 NO 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed Box 68760, P.O. I of Vital Records, or Attending Physician; Division To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

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72 hours after

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After thi funeral

Saltimore, Maryland 21215-0036

traumatic event, the Medical Examinar must be notified at

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State Registrar

Medical

29a. Certifier

(Check only one)

AR 10

29b. Signature and title of certifier

31. Date filed (Month, Day 2008

The

MUNSHED

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, 126

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| | | For State Registrar | State of Maryla | nd / Dep | | lealth and N | /lental Hygi | ene | 008 | 28568 |
|---|-------------------|--|---|---------------------|---|----------------------|------------------------------------|------------|----------------------------------|---|
| Physicia | n | 1. Decedent's Name (First, Middle, Last) | Taber Obs | -1-7- | | | Date of Death Month | Day | Year | 3. Time of Death 7:35 A M |
| /Medic | ai - | do Facilia Nama (Mana) institution since | John Chu | ıkıa | Ab City Town as | r Location of Death | AUGUST | _ | 2008 nty of Death | 7 + 33 Ft M |
| Examine | er | 4a. Facility Name (If not institution, give s Washington County | | | | lagerstow | | 4c. Cou | Washir | acton |
| Funeral | | Social Security Number 6. Sex | 7. Age (In yrs | s. last birthday |) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, | Vane) | 9. Birtho | lace (State or Foreign |
| Director | | 141-18-4494 ¹ 2 | . ^{M 2□ F} 86 | Yrs. | Months Days | Hours Min. | | 1921 | Coun Ol | nio |
| pug * | - | Usual Residence of Decedent 10a. State 10b. County | 10c C | ity, Town or L | ocation | | | | 110 | Od. Inside City Limits |
| f sho | ò | NJ Burlin | | ,, 101111 01 2 | Riverside | | | | | 1 ☑ Yes 2 ☐ No |
| the N | Director | 10e. Street and Number | ig con | | 10f. Zip Code | : | 10 | g. Citizen | of What Coun | try? |
| | | 622 West Washir | ngton Street | | 080 | 75 | | į | J.S.A. | |
| ems ? | Funeral | 11. Marital Status | Was Decedent Ever in I Armed Forces? | U.S. 13 | . Was Decedent of H If Yes, specify Cuba | lispanic Origin? (Sp | ecify Yes or No- | | Race - Americ Black, White, e | |
| or it | by Fu | 1 Never Married 2 Married | 1 □Yes 2 □No If Yes, Give | | 1 □ Yes 2 ☑ No | Specify: | | 1 | oifu: | |
| hour: | ed b | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | 16a Dec | edent's Usual Occup | nation | 1 | 6h Kind o | f Business/Inc | White |
| nin 72 In "na Medic | plet | (Specify only highest grade Elementary/Secondary (0-12) | completed) | (Giv | e kind of work done of DO NOT use retired | during most of work | ing . | ob. rand o | Dadinodanie | adott y |
| d with giene er tha | Be Completed | 10 | College (1-4or 5+) | | Press Op | erator | | Meta | al Indu | ıstry |
| be file tal Hy d oth | Be (| 17. Father's Name (First, Middle, Last) | | | | | e (First, Middle, M | | name) | |
| ould to market narket | ရ | John Chukla | | | | | ne Clocha | | | |
| d 2 sh th and 7 Is n traun | | 19a. Informant's Name/Relationship (Typ. Joseph Chukla (Ne | e. Print) ephew) | | ling Address (Street | | | | | Code) Land 21742 |
| 1 and Healt Healt Healt Sem 2 | ŀ | 20a. Method of Disposition | | | | | | | on - City or To | |
| ages ent of tr: If It | | 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) | emovai irom State | | position (Name of ematory or other place er's Cemet | Hugi | ust 30, | | | , New Jersey |
| permit. Pages 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, tre fredicti Eversi once. | | 21. Signature of Funeral Service License | | | 22. Name and Addre | | 008 J.L. Davi | | | |
| Depa Impo any is | | 1 To be | 1) VIS MO 14 | 14 | 12525 Brad | | | | | |
| Physician /Medical | | 25a Partt. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | cations that caused the dea | | | | | | | Approximate Interval Between Onset and Death |
| te be executed ysician and e burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse | equence of): | et In | puta | | | | 2000 |
| Attending Phystclan: The law requires that the death certifica roteath. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown | tal death 3 | ☐ Ectopic pregnanc | | | 23d. | Date of delive | ery Day Year |
| res that igned be det | by PI | Part II. Other significant conditions con | | | underlying cause giv | ren in Part I. | 23e. Did tob | acco use o | contribute to the | ne cause of death? |
| w require been sign | ted | medine Ly | n- hip x | ent | 1 | <u>~~</u> | 1 □ Ye | s 2 N | o 3 Prot | oably 4 🗖 Unknown |
| : The law cate has b page 2 sh | Completed | Typical De | meete | | | | 24a. Was an autopsy perform | / | | psy findings available mpletion of cause of 2 No |
| stclan: The certificate rector, pagi | Be | 25. Was case referred to medical examine? | ospital: | | ent 3 DOA Oth | or: | th (Check only one | | | |
| nding Phys ith. : After this e funeral dir | Certification: To | 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day, Year) | 28b. Time Injury | of 28c. Inju | ry at | ome 5 Reside 28d. Describe hor | | | (fy) |
| To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | Certifica | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At building, etc. (Spec | home, farm, s | street, factory, office | | 28f. Location (Str City or Town | | umber or Rura | al Route Number, |
| the Hospi iin 24 hou the Funer ipletely fill | Medical | | sician: To the best of my k ner: On the basis of exami and manner stated. | | | | | | | |
| Viith Viith Con | 2 | 29b. Signature and title of certifier | 0/184 | M | 29c. Licens | se number | | | gned (Month, | Day, Year) |
| | | | - TAMO | | e, Print) | e nac | ER STU | w | . ~I) | 21740 |
| Stat Registra | | 31. Date filed (Month, Day, Year) AUG 2 6 20 | 32. Registrar's Sig | nature | Sil | | | | | |

Amended #26, MLU Per Phy. 08/11/08, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ate of Maryland / Department of Health and Mental | Hygiene | 205 | |
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| ate of Maryland / Department of Health and Mental Certificate of Death | Reg. No. 2008 | 285 | 0 (|

Physician /Medical Examiner

Funeral 1 □ M 2 🔀 F Months Days Hours Min. 215-56-7833 Director 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a. State Director ALLEGANY **CUMBERLAND** MD 10e. Street and Number 10f. Zip Code 21502 603 LOUISIANA AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) Be DUKE WILLIAM BURGER 2 19a. Informant's Name/Relationship (Type. Print) t and 2 s Health ar permit. Pages t and the Department of Health Important: If item 27 any Injury or other transonce. HARRY L. CORNELIUS / HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State HILLCREST MEML. PARK | 08/06/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice RULLO Immediate Cause (Final **Physician** END STAGE *LZTEIMERS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 mor 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 should Completed 24a. Was an certificate has page Vital 1 ☐ Yes Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1∐ Yes 2 T No Impatient 2 ER/Outpatient 3 DOA Medical Certification: To of this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? Division Hospital or Attending 1 Natural 5 Pending Injun n 24 hours after death.
he Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier within 24 hor To the Fune completely fi (Check only one To the 29b. Signature 29c. License number nd title of certifier 2 leted cause of death (Item 23a) (Type, Print) Barrera, PLV ... 32. Registrar's Signature Ave Cumberland, MD 21502 31. Date filed (Month, Day, Year) State AUG 1 2008

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARY WONN CORNELIUS A.M 2008 3:25 AUGUST 4, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ALLEGANY ALLEGANY COUNTY NURSING & REHAB CTR CUMBERLAND 8. Date of Birth (Month, Day, Year)
JAN• 16,1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) WEST VIRGINIA 10d. Inside City Limits 1 XYes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc WHITE 16b. Kind of Business/Industry HOME 18. Mother's Name (First, Middle, Maiden Surname) MARY ELIZABETH WONN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21502 603 LOUISIANA AVENUE, CUMBERLAND, MD 20c. Location - City or Town, State CUMBERLAND, MD Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YRS 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 □ No 1 ☐ Yes 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year)

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 28570 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Gloria Darlene Crawford August 18 2008 8:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 14204 Canal Road, SE Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 ☐ M 2 🖫 F 56 Yrs. 217-54-6539 05/14/1952 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14204 Canal Road, SE USA 21502 by Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Duane Lantz Wilma Grace Stafford ္ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If Item 27 is any Injury or other trau Roger D. Crawford / Husband 14204 Canal Road, SE, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) MD Vet Cem @ Rocky Gap 08/22/2008 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Lice 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition Dendux Physician 6 year resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sers consequence offi Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 220 No 24a. Was an page 2 s autopsy certificate To the Hospital or Attending Physiclan: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 25 Hospital: 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of D 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 latural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. he Funeral Director: A pletely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 imedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M/ D46346 August 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, Cumberland, Maryland Huma Shakil, M.D. 21502 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 1 9 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 19,2008 11:00am MARVA MARIE CHATMAN /Medical Aug 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 10400 Boswell Lane Potomac Inder 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 M 3 F 234-68-1159 Director 66 June 14,1942 West VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1K Yes 2 □ No Michigan Wayne Detroit 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8860 Manor Street 48204 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service District Manager is 1 and 2 should be filed wi f Health and Mental Hygier tem 27 Is marked other th yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert E. Thomas Lillie Belle Ware ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor L. Crawford (Son) 10400 Boswell Lane, Potomac, MD 20854 item 27 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or conce. 1X Buriał*) 2 ☐ Cremation 3 Removal from 8/25/08 Woodlawn Cemetery Detroit, MI 4 Doylation 5 Dother (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Sign ky e Funeral Service Li 246 N. Washington St Rockville,MD 20850 23a Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final **Physician** 6a6/8 disease or condition resulting in death) 3774 /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. burial-tran Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy certificate 1 ☐ Yes 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) er mo one 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park N BRECHER mo omE 31. Date filed (Month, Day, Year) legistrar's Signature Registrar 2008

08-06435 Glenn A. Chase Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amenda 170 Print Yand 6883 and 686 98 Health and Mental Hygiene

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| | | I-For State amend #8 | Per FH G88 | o centifi | cate of t | Death | | Re | eg. No. | 100 2001 | |
|---|---|--|--|-------------------------------|------------------|---|----------------|------------------------------|--|---------------------------------|--|
| Physici | icism/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time o | | | | | | | | 3. Time of Death | | |
| ledical Exami | iner | Month Day | | | | | | | Day Year , 2008 | 1733 hrs | |
| | | 4a. Facility Name (if not institution | | | 4b | City, Town, or L | ocation of Dea | | 4c. County of | Death | |
| | | 40555 Kavanaugh Roa | | | | Mechanicsvil | | | St. Mary's | | |
| | | - 131 A | | o (lours lost b | iethdou) | If Under 1 Year | If Under 241 | Ire 8 Date of Bir | HAMMOD LOAR | 9. Birthplace (State or Foreign | |
| Funeral | | | F0 | e (In yrs. last b | | Months Days | | lin. | III (MIM/DD/II) FI | Country) | |
| Director | | 578-66-8207 | 1X M 2 F | -59 | Yrs. | Wichais | ,10010 | "" August | 28, 1949 | Washington,DC | |
| | | Usual Residence of Decedent | | | | | | | | | |
| any. | | 10a. State 10b. County Maryland St. Ma | | 10c. City, Tov Mech | vn or Location | | | | | 10d. Inside City Limits | |
| T | | Maryland St. Ma | ary's | Mech | anicsv | ille | | | | 1 Yes 2 X No | |
| Maryland 28a-f show any: 1 at once. | Director | 10- 044 11 | | | | 101 7:- 0-1- | | 14 | 0g. Citizen of What | Country? | |
| Mar 288 | e | 10e. Street and Number 40555 Kavanau | ah Da | | | 10f. Zip Code 20659 | | - ' | USA | Country ? | |
| 215-0036 be filed within 72 hours after death with the Maryland mal Hygiene, other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once | | א כככיי אמוומען | gii Ku. | | | 20033 | | | USA | | |
| with with ns 2, ne n | Funeral | 11. Marital Status | 12. Was Decedent | | | | | Specify Yes or No | | American Indian, Black, | |
| eath iter | Ĕ | 1 Never Married 2 Ma | rried Armed Forces? | X No | 1 | , specify Cuban, | | rto Rican, etc.) | White, | -0 | |
| | Ē | 3 Widowed 4 X Divo | rced If Yes, Give Year | - NO | 1 7 Y | es 2 No | specify: | | Specify: | White | |
| 1215-0036 Id be filed within 72 hours after death Hygene, marked other than "matural", event, the Medical Examiner. | by | 15. Decedent's Education (Spec | or Dates: | noleted) 16 | | Usual Occupation | | of work done | 16b. Kind of Busin | ness/Industry | |
| hou hou Exa | Completed | Elementary/Secondary (0-12) | College (1-4 or | | | t of working life. I | | | | , | |
| 36 n 72 nan ' | e | 12 | College (144 of | 3+) | Carpe | t Mechai | nic | | Car | pet | |
| withi ene. | 틸 | | | | | | | | | L | |
| 21215-0036 vuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica | ၂႘ | 17. Father's Name (First, Middle, | Last) | | | 1 | | me (First, Middle, | | | |
| 2121: uld be fil Mental I marked c event, | Be | Lawrence Chas | se | | | | Wini | Fred Wint | her | | |
| Me Me | 으 | 19a. Informant's Name/Relationsh | ip (Type, Print) | | 19b. Mailing A | ddress (Street | and Number | or Rural Route Nur | nber, City or Town, | State, Zip Code) | |
| L sho | 9 | Marie Chase/Da | aughter | - 1 | 40570 | Kavanau | eh Rd. | Mechani | csville. | MD 20659 | |
| Baltimore, MD 27 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er | | 20s Mothad of Disposition | | 20h Digo | o of Diaponiti | on (Name of com | otor. | Date | | City or Town, State | |
| Orthorn If in her | | 1 Burial 2 X Cremation | 3 Removal from St | ate primer | natory or othe | r place) | C | August | | | |
| Pag Pag Pag Pag Pag | | 4 Donation 5 Other Spe | ecify: | PLIUS | rrera- | ECHOIS | crem. | 27, 2008 | Charlo | tte Hall, MD | |
| alti mit. porti | | 21 Signature of Funeral Service I | | | 22. Na | me and Address | of Facility B | rinsifeld | l-Echols | F.H., P.A., | |
| ini In De Pa | | Marston Co | MOD MOO |) 817 | | | | | | Hall, MD 20622 | |
| Physician | | 23a Part I Enter the disease or o | complications that caused | | | | | | | | |
| /Medical | | failure. List only one cause of | on each line. | | | | | | | Between Onset and Death | |
| xaminer | | Immediate Cause (Final disease | a. Contact Shotgu | | of Head | | | | | Death | |
| | | or condition resulting in death) | Due to (or as a cons | equence of): | | | | | | | |
| | ١. ا | Sequentially list conditions, | b | | | | | | | | |
| | Examiner | if any, leading to immediate | Due to (or as a cons | equence of): | | | | | | | |
| | Ē | Course Enter Underlying Course (Disease or injury that initiated C | | | | | | | | | |
| sit sq | 🎇 | events resulting in death) Last | Due to (or as a cons | equence or): | | | | | | | |
| ecute and trar | | | d | | | | | | | | |
| se ex cian | 응 | UNPENDED | AMENDED | | | | | | | | |
| 18760, rificate be executed ing physician and as the burial - transit | | IF FEMALE: | 23c. If yes, outcome | me of pregnan | су | | | | 23d. Date of d | elivery | |
| 1987 rtific as th | <u> </u> | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | | 2 Feta | Ideath 3 | Ectopic pre | gnancy | Month | Day Year | |
| Box 68 e death certi the attendin ed for use a | Physicia | | , <u> </u> | time of death | 5 Othe | r (Specify) | | | 3300 | | |
| Bo le dear the ar | S | 1 Yes 2 No 9 Unk | nown g Unknown | | | | | | | | |
| that the | | Part II. Other significant condition | ons contributing to deat | h but not resul | ting in the un | derlying cause gi | ven in Part I. | 23e. Did t | obacco use contrib | ute to the cause of death? | |
| P.O es that t igned by | ğ | | | | | | | 1 Ye | s 2 🗸 No 3 | Probably 4 Unknown | |
| IS, Francisco | Completed | | | | | | | - 24a. Was | an 124h W | ere autopsy findings available | |
| of Vital Records, ng Physician: The law require. The this certificate has been si meral director, page 2 should b | <u>e</u> | | | | | | | auto | psy pri | or to completion of cause of | |
| e Constant of the part of the | ΙĘΊ | | | | | | | | | ath? ✔ Yes 2 No | |
| tal Recian: The | | 05 10 | 7 | | | 06 Diago | of Death (Che | | 2 110 | 7 163 2 160 | |
| Vital Rec ysician: The his certificate director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Thor. | | | | |
| Vinysia This | ပ္ | 1 ✔ Yes 2 No | тпраш | | /Outpatient | 0 20 | | rsing Home 5 | Residence 6 | | |
| n of \ ding Phy After th funeral | | 27. Manner of Death | 28a. Date of Inj (Month, Day,) FOUND: | ury 28 Year) | b. Time of Inj | ury 28c. Injur | y at Work? | 28d. Describe Subject sho | how injury occurre | d | |
| ion trendi leath. tor: | 유 | 1 Natural 5 Pendi | "I'9 A 00 0000 | | OUND: 729 hrs | 1Y | es 2 🗸 No | Oubject site | 7. 3011 | | |
| ivision or Atteno after death Director: | <u>s</u> | 28e. Place of Injury - At home, farm, street | | | | reet, factory, office building, etc. 28f. Location (S | | | treet and Number or Rural Route Number, City | | |
| | Certification: | deter | Suicide Could not be determined (Specific) Cinate Families | | | | | | or Town, State) 0555 Kavanaugh Road, Mechanicsville, MD | | |
| D To the Hospital within 24 hours To the Funeral | ပိ | 4 Homicide | (op com)/ Oil | | | | | | | | |
| e Ho r 24 e Fu etely | g | (Check only | ysician: To the best of m | | | | | | | | |
| To the Hos within 24 h To the Fun completely | Medical | one) 2 Medical Exam | niner: On the basis of exa and manner stated. | mination and/o | or investigation | n, in my opinion, | death occurre | ed at the time, date | and place, and du | e to the cause(s) | |
| F 3 F 8 | Σ | 29b. Signature and title of certifier | | | | 29c. License | number | | 29d. Date signe | d (Month, Day, Year) | |
| | | DAINT | on. | | | O.C.M.E. | | | August 23, 2008 | | |
| | | Will 2 | | | | | | | | | |
| - | | 30. Name and address of person | · | • | , | | | | | | |
| | | | | | 4 Dame Ct | D . H' | BAD 041 | <i>1</i> 111 | | | |
| | | Ana Rubio MD. Assi | istant Medical Exar | niner 11 | 1 Penn St | reet, Baltimo | re, MD 212 | 201 | | | |
| S | tate | | | niner 11 ar's Signature | 1 Penn St | eet, Baitimo | re, IVID 212 | . – | | | |

State of Maryland / Department of Health and Mental Hygien 2018 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day Year **Physician** August 22, 7:00 a M 2008 Michael Chlvsta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf 4840 Young Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 21, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1⊠M 2□ F 1919 Pennsylvania Director 162-14-4650 89 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1 Yes XXNo Directo Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 20601 USA 238 4840 Young Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 図Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 257 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced White "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: if Item 27 is marked other then "ns any injury or other traumatic event, The Madia 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Package Products, Inc. Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Chlysta Mary Harry ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Wisniewski/Daughter 4840 Young Rd., Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oueen of Peace 8/26/2008 Mechanicsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, MD 20622 (chols) M00817 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes XXNo funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending investigation s after de-rai Director: After 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in t ☑ Certifying Physiciam: To the best of my knowledge death cerumed at the time date and class and due to the nause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated. 200 Carrier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19431 August 22, 2008 30. Name and address of person wo completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd., Ft. Washington, MD 20744

DHMH 17 Rev 1/2001

State Registrar

Dr. Frank Ryan 31. Date filed (Month, Day, Year) AUG 2 8 2008

32. Registrar's Signature

| | | | For State Registrar | State of Marylan | | artment of H | | ntal Hygiens | .000 | 28575 |
|----------------------------|---|------------------|--|--|----------------------------------|---|---|---|--|--|
| | Physici /Medic Examin | al . | Decedent's Name (First, Middle, La Leonard C 4a. Facility Name (If not institution, give | D. Davis | | 4b. City, Town, or | Location of Death | | 200 County of Deat | h |
| | Funeral Director | | 491-44-6499 | | last birthday) Yrs. | Silver If Under 1 Year Months Days | If Under 24 Hrs. 8 Hours Min. | . Date of Birth (Month, Day, Year) 19/08/1943 | ontgome 9. Bird Co Wyat | hplace (State or Foreign untry) , Missouri |
| | se Maryland 8a-f show | Director | Usual Residence of Decedent 10a. State 10b. County Md. Montg | | y, Town or Lo Silver | Spring | | | | 10d. Inside City Limits 1 Yes 2 No |
| | 23a or 24 | | 10e. Street and Number 1000 Daleview | Drive | | 10f. Zip Code 20901 | | | tizen of What Co | |
| 980 | n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show polical Exeminer must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced | 12. Was Decedent Ever in U Armed Forces? 1 [ZYes 2 No If Yes, Give 65- | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ★ No | ispanic Origin? (Speci n, Mexican, Puerto Ri Specify: | fy Yes or No- can, etc.) | 14. Race - Ame Black, Whit A: Specify: Ar | |
| 21215-0036 | within 72 ene. than "na | Completed | 15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) | ducation ade completed) College (1-4or 5+) 4 Yrs. | (Give | dent's Usual Occup kind of work done o DO NOT use retired | ation during most of working d) | | (ind of Business S. Posta | Industry |
| Maryland 2 | be file ital Hyg id othe event, | To Be C | 17. Father's Name (First, Middle, Last Lafayette Davis | | | | 18. Mother's Name (| First, Middle, Maidei a Green | n Sumame) | |
| | l and 2 s dealth ar mm 27 is ther trau | | 19a. Informant's Name/Relationship (Carolyn Wiggins/ 20a. Method of Disposition | Sister 206. F | 13395 | Coppermi | Dat | 402,Hern | | inia 20171 |
| Baltimore, | nit. Page artment o ortent: If injury or | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lice | (y) O | ak Gro | ve Cem. Name and Address | · I | | | n,Missouri |
| ı | | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only | one cause on each line. | th. Do not ent | 925 BUTTO er the mode of dyin | ig, such as cardiac or | N.E., Wash respiratory arrest, | ington, | Approximate Interval Between Onset and Death |
| | Physician /Medical Examiner | er | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | Due to (or as a consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or a) consect b. Due to (or | quence of): | dea ou | NOMA | Krz Ma | Ny J | mont s |
| 8760, | ate be executed sysician and he burial-transit | icai Examin | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | quence of): | | | | | |
| O. Box 6 | death certifica e attending ph ad for use as t | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c | aldeath 3 | Ectopic pregnancy Other (specify) | 1 | | 23d. Date of de Month | livery Day Year |
| <u>α</u> | sign d be | þ | Part II. Other significent conditions | contributing to death but not res | | , , | en in Part I. | | | o the cause of death? |
| Division of Vital Records, | | Completed | | • | • | | | 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N | prior to death? | utopsy findings available completion of cause of |
| Vit | Physician: this certific ral director, | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatie | nt 3 DOA Oth | 26. Place of Death (| *Check only one) e 5 ☐ Residence | 6 ☐Other (Spi | ecify) |
| sion of | ding After fune | Certification: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | f 28c. Injur Wor M 1 | y at 28 k? Yes 2 □ No | d. Describe how inj | ury occurred | |
| Divi | i Di de | | 4 Homicide determined | building, etc. (Speci | ry) | | | Bf. Location (Street a City or Town, Sta | te) | |
| | the Hospital hin 24 hours the Funeral hpletely filled | edical | 29a. Certifier 1 Certifying P (Check only 2 Medicel Exe | hysicien: To the best of my knominer: On the basis of examination and manner stated. | owledge, deat ation and/or in | n occurred at the tir vestigation, in my o | me, date and place, an opinion, death occurred | d at the time, date ar | s) and manner a 1d place, and du | s stated. e to the cause(s) |
| | To the h within 24 To the F | Σ | 29b. Signature and title of certifier | (10.)-0 | 1- | 29c. Licens | | | ate signed (Mon | |
| | 96 | | 30. Name and address of person who | completed cause of death (Itel | m 23a) (Type, | Priqt) | 18 30 | 11 | 6-UST | 20 2018, M) 2018, |
| | Sta | to. | Paul A. Sel 31. Date liled (Month, Day, Year) | ORE MS 32. Registrar's Sign | 4203 (ature | ween: | sbury 141 | Myats | 130,1/4 | 140 2078, |
| | Regist | | AUG 2 5 2008 | Brand & A | book | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | For State Registrar | Certificate of Death | Reg. No. 2008 28576 |
|--|--|---|---|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last) James Rudolph Ellis | | 2. Date of Death Month Day Year August 27, 2008 1:10 p.m. |
| Examiner | 4a. Facility Name (If not institution, give street and number) St. Mary s Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. | 4b. City, Town, or Location of Death Leonardtown last hirthday) ff Under 1 Year ff Under 24 Hrs. | St. Mary's |
| Funeral Director | 5. Social Security Number 578-03-4768 6. Sex 7. Age (<i>In yrs.</i> 7. Age (<i>In yr</i> | Yrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington, DC |
| a-f show | | y, Town or Location | 10d. Inside City Limits 1 □Yes 2 🖔 No |
| fier death with the Mar ritems 23a or 28a-f sl finer must be mattled Funeral Director | 10e. Street and Number 45138 Lighthouse Road | 10f. Zip Code 20674 | 10g. Citizen of What Country? United States |
| | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: | S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- Prican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White |
| ad within 72 hours a ygiene. er than "natural", of the world Even. t, I'm world Even. | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) U.S. Postal Carrier | 16b. Kind of Business/Industry U.S. Government |
| the filed Hyge ed other; event, Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Nam | e (First, Middle, Maiden Surname) |
| 12 should h and Mer 7 Is marke traumatic | James Henry Ellis 19a. Informant's Name/Relationship (Type. Print) | | Agnes Heatter ral Route Number, City or Town, State, Zip Code) |
| ages 1 and ent of Healt it: If item 27 y or other 1 | LABORIA 2 LI Cremation 3 Li Hernoval from State | remetery, crematory or other place) | Date 20c. Location - City or Town, State |
| permit. P Departme Importan any Injur | 21. Signature of Funeral Son to Doensee | | 0/2008 Suitland, Maryland Insfield Funeral Home, P.A. |
| Physician /Medical | 23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause the action limediate Cause (Final disease or condition resulting in death) | n. Demot enter the mode of dying, such as cardiac | or respiratory arrest, Approximate Interval Between Onset and Death |
| Examiner ਹੁ | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for is a consequence to be a consequence of the cause of the c | | Torofficions |
| rifificate be executed as physician and as the burial-transit | Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conseq | uence of): | |
| £ 5, a € | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constitution of the pregnant at time | death 3 Ectopic pregnancy | 23d. Date of delivery Month Day Year |
| w requires that the de been signed by the should be detached letteched by Physical by Phys | Part II. Other significant conditions contributing to death but not res | ulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Likiknown |
| : The law requii cate has been s page 2 should | Vascular disesse | | 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No |
| Physician: The this certificate I al director, page | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ | Othor | th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify) |
| ng I | 27. Manner of Death 1 ☑ Natural 5 □ Pending investigation 3 □ Suicide 4 □ Homicide determined 28a. Date of Injury (Month, Day, Year) 28b. Place of Injury - At he building, etc. (Specification) | 28b. Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No me, farm, street, factory, office | 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, |
| ospital or hours afte ineral Dir y filled in | 29a. Certifier 1 Certifying Physician: To the best of my kno | wledge, death occurred at the time, date and place | City or Town, State) , and due to the cause(s) and manner as stated. |
| To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu Medical Certificati | (Check only one) 2 Medical Examiner: On the basis of examina and manner stated. 29b. Signature and title of certifier | tion and/or investigation, in my opinion, death occu | rred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) |
| | 30. Name and address of poson who completed cause of death (Iten | D46374 | 8/27/2008 |
| | HUTHOND/ NOWOO. | MD 2500 BINT Look | out Road (conordonn M) |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician E. Ebron August 18, 7:15 John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 578-80-6340 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🔀 M 2 🗆 F Director April 4, 1957 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Experiment, sat be retilined at any injury or other traumatic event, the Madical Experiment, sat the retilined at anones. 10d. Inside City Limits 10c. City, Town or Location 1 √2 Yes 2 □ No Director District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral [324 Oneida Street, NW 20011 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No \$ Specify: Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years <u>Maintenance Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morris B. Ebron Pauline Saunders ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pala Davis - Sister 324 Oneida Street, NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Aug 25, 2008 Landover, MD Harmony Mem. Park 22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Par 1. En er the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoch or leart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hepatocellular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): ospital or Attending Physician: The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy this certificate has been signed by the atte al director, page 2 should be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 4 hours after death.

Uneral Director A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person wh

Sures

3

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records.

completed cause of death (Item 23a) (Type, Print)

tel-m

D46478

8-18-88

Surratts Rd. Clinton MD20735

| | | 1 | 1 - State Registrer Amend It | enis 23 | arvaryi | nd / Depa Cei | ntment of H | lealthand Beath | 8/29/08/III | Bn@ () () | 8 2 | 8578 |
|-------------|--|----------------|--|-----------------------|--------------------------------------|---|---|--|---|-----------------------------|--|---|
| | Physici | an | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of Death Month | Day \ | 3. T | Time of Death |
| | /Medic | | | | | iallo | | | July | | 800 | 9:45 a ^M |
| | Examin | er | 4a. Facility Name (If not institution, give | e street and n | u <i>mber)</i> | | | Location of Death | | 4c. County of | | |
| _ | | | Fairland Nursing & F 5. Social Security Number 6.5 | | + | enter | If Under 1 Year | Silver Spri | | | Montgome: | |
| | Funeral Director | | | M 2 X F | | 96 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day,) June 23, | Year) | Country) Ecuado | State or Foreign |
| | | | Usual Residence of Decedent | | | 70 | | | Julie 23, | 1712 | Leade | /L |
| | yland | | 10a. State 10b. County | | 10c. | City, Town or Lo | cation | | | | 10d. In | side City Limits |
| | Mar III | to | Maryland Montgo | mery | | | | Silver Spr | ing | | 1[| ∐Yes 2.KINo |
| | th the | Director | 10e. Street and Number | | | | 10f. Zip Code | | 109 | g. Citizen of Wh | at Country? | |
| | death with the Maryland ms 23a or 28a-f show Triust te rivilled at | | 210 Nort | hmoore I | rive | | | 20901 | | Ec | uador | |
| | | Funeral | 11. Marital Status | 12. Was De Armed F | cedent Ever ir Forces? | 1 U.S. 13. \ | Was Decedent of Hi f Yes, specify Cuba | ispanic Origin? (S in, Mexican, Puert | pecify Yes or No- o Rican, etc.) | | American Inc. White, etc. | tian, |
| 30 | filed within 72 hours after Hygiene. thar than "natural", or Ita int, the Medical Examira | by Fi | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced | If Yes, G | | | 1∰Yes 2□No | Specify: Ecu | adorean | Specify: | C | and an |
| 12-0036 | hour tural | | 15. Decedent's E | Year or | Dates: | 16a Decer | lent's Usual Occupa | | | 6b. Kind of Busi | | ucasian |
| 'n | in 72 | Completed | (Specify only highest gr | de completed | | (Give | kind of work done of NOT use retired | during most of wor | king | go, Kilia oi basi | 110532111GGS(I) | |
| 717 | with iene. thar | mo | Elementary/Secondary (0-12) | College | (1-4or 5+) | | Homen | naker | | (| Own Home | |
| 0 | Hygi Othar | Be C | 17. Father's Name (First, Middle, Last |) | | | | 18. Mother's Nan | ne (First, Middle, Ma | aiden Sumame, |) | |
| a | lid be lental rkad c | To B | Celso Fiallo DeSa | nMiguel | | | | | Saa Noboa | | | |
| Mary | as 1 and 2 should be for Health and Mental Fitam 27 is marked of rother traumatic evair | | 19a. Informant's Name/Relationship | Турө, Print) | | 19b. Mailir | g Address (Street a | and Number or Ru | ıral Route Number, (| City or Town, S | tate, Zip Code |) |
| _ | and 2 ealth a n 27 ls | | Gloria Montelongo - | Daughte | er | 210 | Northmoore | e Drive, Si | ilver Spring | , Marylaı | nd 20901 | |
| e, | of He fitan | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ | Domoval from | 1 | Place of Dispo cemetery, crer | sition (Name of natory or other plac | :0) | Date 20 | 0c. Location - C | ity or Town, S | tate |
| IIII | Pages nent of ent: If its ury or o | | '4 □Donation 5 □Other (Speci | | I . | Fort Linco | In Cremator | ry 07/3 | 31/2008 | Brentwood | d, Maryl | and |
| Bail | permit. Pages Department of Importent: If it, any injury or o | | 21. Signature of Funeral Service Lice | 10 0 | K | H | Name and Addressines-Rinald | ii Funeral | Home, Inc. venue, Silve | er Spring | Marvla | nd 20904 |
| ľ | ě. | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that | caused the d | | | | | | Appr Inter | roximate val Between et and Death |
| | Pnysician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a | | ary Syndro | me | | | / | - I | nstant |
| | Examiner | | 1 | Due to | o (or as a cons | sequence of): | | | 1 | 11 | | |
| | | Ē | Sequentially list conditions, if any, leading to immediate | b. Due to | o (or as a cons | sequence of): | | | APPROVED BY MEDICA | MER | | |
| | uted | Examiner | if any, leading to immediate cause. Enter Underlying Cause Ulsease or injury | | | | | | N CONTROCK | TEXAM | | |
| 'n, | be executed ician and buriai-transit | Exa | that initiated events resulting in death) Last | c. Due to | o (or as a cons | sequence of): | | Time | PPROVEDE | | | |
| ۾/م م | cate be executed ohysician and the buriai-transit | dical | | d | | | | CERTIFICATION | | | | |
| ٥ | certificate nding phys use as the | led | | | | | | | | - | | |
| X Q Q | leath certific attending pl | hysiclan/Me | IF FEMALE: 23b. Was decedent pregnant | | utcome of pre | | Ectopic pregnancy | | | | of delivery | |
| n | e death he atten | sick | in the past 12 months? 1 🗆 Yes 2 🗷 No | | gnant at time o | | Other (specify) | | | Mont | th Day | Year |
| r O | at the de | Phy | 9 Unknown | | | | | | 64 511 | | | |
| ທົ | requires that een signed b | by | Part II. Other significant conditions | | death but not | resulting in the u | nderlying cause give | en in Part I. | | acco use contrib | | |
| cord | w require been sig | ted | Respiratory Failure | : | | | | | 1 Tes | s 2□No 3 | - Probably | 4 XUnknown |
| Ö | aw Is b | Completed | Subdural Hematoma | | | | | | 24a. Was an autopsy | pri | ior to completi | ndings available ion of cause of |
| E S | th page | Con | Hypertension | | | | | | perform 1 ☐ Yes 2 | ed? de Mo 1£ | eath? ⊒Yes 2∐1 | No |
| /113 | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | 11 | | | | | ath (Check only one | | | |
| 010 | S S | 2 | 1ÆYes 2⊞No | | | ER/Outpatier | | | lome 5 Resider | | | |
| lon | ath. r: After e funera | atlon; | 27. Manner of Death Thatural 5 Pending 2X Accident investigation | 05/0 | e of Injury 2 <mark>7/2008</mark> | Unknow | 28c. Injun Work | | 28d. Describe how Subject | | d | |
| DIVISION | l or Atta after de Diracto I in by th | Certification; | 3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined | 280. Pla | ding, etc. (Spe | t home, farm, str ecify) | eet, factory, office | | 28f. Location (Stre City or Town, Drive, S: | et and Number State) 210 | North | te Number, noore MD |
| | he Hospital or Attanding Ph in 24 hours after death. ha Funaral Diractor: After th pletely filled in by the funeral | Medical C | (Check only 2 Nedical Exa | niner: On the | basis of exam | | | | a, and due to the cau | use(s) and man | ner as stated. | |
| | | Mec | 29b. Signature and title of certifier | and ma | inner stated. | | 29c. License | e number | 29 | d. Date signed | (Month, Dav. | Year) |
| | To Too | |) (Koz | | | | 255. 6100/134 | | | - | | _ |
| | | | 20 Name on the same | completed a | uen of de -th. " | Itom (22a) (T | Deine) | D28656 | | July | 23, 200 | ō |
| | | | Ravi Passi, M.D., | | | | | ockville) | Maryland 209 | 350 | | |
| | Sta | te | | 32 | Plegistrar's Si | gnature | | | | | | |
| | Registr | | 31. Date filed (Month, Day, Year) | 008 | Muse | 15 190 | and i | | | | | |
| _ | | | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** WILLIAM FRANKLIN FITZGERALD 5:55 AM 20, August 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 11541 Scottsbury Terrace Germantown 6. Sex 1 A M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 71 Dec. 22, 1936 Washington D.C. Director 578-50-0332 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinst must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20876 United States Funeral 11541 Scottsbury Terrace 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ₹ Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Lithography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Elizabeth Watson ၉ Thomas F. Fitzgerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tratonce. <u> Joyce Ann Fitzgerald/Wife</u> 11541 Scottsbury Terrace, Germantown, MD. 20876 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery 8/22/2008 Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Superitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq Examine the death certificate be executed signed by the attending physician and I be detached for use as the burlal-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Fafter death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and D0063196 mpleted cause of death (Item 23a) (Type, Print) Drive Ste 100 Piccord C. HANdrew 1355 31. Date filed (Month, Day, Year) State 21 2008 Registrar

| | | 1 - For State Registrar | State of Mar | | epartment of F Certificate of I | | Re | eg. No. 2000 | |
|---|------------------|---|--|-------------------------------|--|--------------------------------|--|--|--|
| Physic | ian | 1. Decedent's Name (First, Middle, La Sylvia Rosenbloom | | | | | 2. Date of Death Month August 1 | 16 Day 2008 Year | 3. Time of Death 6:50 P M |
| /Med Exami | | 4a. Facility Name (If not institution, giv | | | 4b. City, Town, o | r Location of Death | | 4c. County of Dea | |
| - Admi | | Collingswood Nurs | sing Home | | Rockvil | | | Montgome | |
| Funera Director | | 188-01-7439 | ex | In yrs. last birtl | hday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 01/15/1 | Year) C | thplace (State or Foreign ountry) |
| land ow | | Usual Residence of Decedent 10a. State 10b. County | 1 | 0c. City, Town | or Location | | | | 10d. Inside City Limits |
| a-fsh | cto | MD Montgome | ery | Rockvi | .11e | | | | 1X Yes 2 □ No |
| th with the 23a or 28 | Funeral Director | 10e. Street and Number 299 Hurley Avenue | 2 | | 10f. Zip Code 2085 | 0 | 1 | 0g. Citizen of What C | ountry? |
| Idryland AIAID50 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Marical Examinan must be notified at | by Fune | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Even Armed Forces? 1 □Yes 24 No If Yes, Give Year or Dates: | er in U.S. | 13. Was Decedent of H If Yes, specify Cub | | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | te, etc. |
| 72 ho | Completed | 15. Decedent's E (Specify only highest gra | ducation ade completed) | 16a. | Decedent's Usual Occur (Give kind of work done | during most of work | | 16b. Kind of Business | s/Industry |
| within sene. | am | Elementary/Secondary (0-12) | College (1-4or 5+) | Te | `life. DO NOT use retire acher | d) | | Educatio | n |
| filed v Hygic Sther ent, th | ပိ | 17. Father's Name (First, Middle, Last | , | | | 18. Mother's Name | e (First, Middle, f | | |
| ed ala | To Be | Edward Rosenbloom | n | | | Rose Ro | senberg | | |
| re, Maryla s 1 and 2 should f Health and Mer item 27 is marke other traumatic | ľ | 19a. Informant's Name/Relationship | | 19b. | Mailing Address (Street | and Number or Rui | ral Route Number | , City or Town, State, | Zip Code) |
| ≥ ¬ = ► = | | Richard Gellman- | Son | | 09 Primrose | | | nersburg, 20c. Location - City o | |
| Baltimore, in permit. Pages 1 and Department of Heal Important: If item 2 any injury or other | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Special Content of the Conten | fy) | | Disposition (Name of y, crematory or other pla avid Meml G | dn 08/20 | /2008] | Falls Chur | ch, VA |
| Departification of the policy | | 21. Sign ture of Fund Furvice Lice | | | | | | Goldberg M lle Pike MD 20852 | |
| Physiciar /Medica Examine | | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a | Pira | L . A. | ng, such as cardiac | \$ | est, | Approximate Interval Between Onset and Death |
| 68 / 60, fificate be executed g physician and as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a c. Due to (or as a d. | | of): | I by IV | ę. | | |
| BOX teath certification attending for use as | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t | Fetal death | 3 ☐ Ectopic pregnan 5 ☐ Other (specify) | су | | 23d. Date of d Month | lelivery Day Year |
| 2 0 9 | 2 | A A A A | contributing to death but | not resulting in | the underlying cause gi | ven in Part I. | | | to the cause of death? Probably 4 Unknown |
| The larate has | Completed | | | | | | 24a. Was a autop perfor 1 □ Yes | ev prior t | autopsy findings available o completion of cause of? |
| t Vital ysiclan; T is certificat director, pa | Be | | - I I Mark | | | | th (Check only or | ne) | |
| n of ng Phys Affer this uneral di | T.uc | | 28a. Date of Injury (Month, Day, | / 28b. | Time of njury 28c. Inju | ıry at ırk? | | ence 6 Other (Sp ow injury occurred | pecify) |
| DIVISION OF i or Attending Phy after death. Director; After this d in by the funeral d | Certification. | 2 Accident investigation 3 Suicide 6 Could not 4 Homicide determine | | ry - At home, fa (Specify) | m 1 E |]Yes 2□No | 28f. Location (S City or Tow | Street and Number or vn, State) | Rural Route Number, |
| DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Olical | | Physician: To the best of aminer: On the basis of and manner stat | examination ar | | | | | |
| To the comp | Me | 29b. Signature and title of certifier |)m | M | 99c. Licer | 150 6 24 | 135 | 29d. Date signed (Mo | 20850 |
| 4 | | 30. Name and address of person who | 44H) 10 | 110 M | (Type Print) alcher D | r. Roc | kville | MD | 20850 |
| Regis | | AUG 2 1 20 | Registral | rs Signature | porte | | | | |

Registrar DHMH 17 Rev 1/2001

Examiner The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician the for use as attending been signed by the should be detached page 2 s certificate the Hospital or Attending Physician:

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once.

Physician /Medical

2 should be filed within 72 hours after death with n and Mental Hygiene.

is marked other than "natural", or items 23a or:

3altimore, Maryland 21215-0036

hours a er death.

uneral Director: After this certific
ly filled in by the funeral director, within 24 hours a

| Parvav in | Contributing to death but not resulting in the directly in | ig cause given in Faith. | 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown |
|---|--|--|--|
| | | | 24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No |
| 25. Was case referred to medical | | 26. Place of Death | h Check onl one |
| examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ | DOA Other: 4 Nursing Ho | ome 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
| 3 Suicide 6 Could not be determined | | ctory, office | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa | hysician: To the best of my knowledge, death occu miner; On the basis of examination and/or investige and manner stated. | rred at the time, date and place, ation, in my opinion, death occur | and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s) |
| 29b. Signature and title of certifier | | 29c. License number | 29d. Date signed (Month, Day, Year) |

29d. Date signed (Month, Dav. Year) 29c. License number

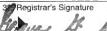
30. Name and address of person who completed of death (Item 23a) (Type, Print) Madecal

Pous. Md. 21401.

State Registrar

Medical

31. Date filed (Month, Day, Year) 2 1 2008 AUG



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraMEND#26perMD, 8-21-08, EMW., Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4602 Harlan Street Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) March 16, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 X M 2 □ F Months 168-03-7916 1916 Pennsylvania 92 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the McGical Examiner must be notified at 1 ☐ Yes 2 TNo Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4602 Harlan Street 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify 3 Widowed 4 Divorced Year or Dates: WWII White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 4 Certified Public Accountant Own Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Anthony Galate Mary Sberna 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vesta D. Galate/Wife 4602 Harlan Street, Rockville, MD 20853 altimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition : cof . 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 21, permit. Page Department Important: If any Injury or Aug. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Manyland 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on Lag. line. g, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to s a conseque te of): Examiner se quentially list conducts, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a con attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ned by the atter 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

24 hours after deatl Funeral Director: Hospital completely within 2 To the

State

31. Date filed (Month. Registrar

29b. Signature and title of certifier

Year 2

Registrar's Signature

29d. Date signed (Month, Day, Year)

20+1

Please Type or Print in Black Indelible lok. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month August Day Year **Physician** 353 PM Katherine 2008 Ghessie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F 15,1914 Pennsylvania 578-58-9434 Director 93 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examiner must be recitived at 1 XYes 2 ☐ No Director Maryland Prince Georges New Carrollton 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code KATHERI 6410 Jodie St 20784 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐Yes 2√2 No Specify ş 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Clerk Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Mykut Mary Mudryk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078419a. Informant' Plane (Belationship (Type. Print) Mary Posic (daughter) 6431 Fairborn Terrace New Carrollton, MD permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other th altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 8/23/08 | Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home Ilno 9013 Annapolis Rd. Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. Party Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Moracic Aortic Immediate Cause (Final **Physician** 01 day pTure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tuoracec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown ate has been signed page 2 should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No Division of Vital 1 ☐ Yes 2 🛮 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne⊮of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 1525 Greenway Ctr Dr Greenbelt MD 20770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6) AMAL MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z U U O 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 11:30PM ^M August 21, CARINER T. GORHAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Temple Hills 2900 Oxon Park Street Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F HYDE NC 2/20/1926 Director 242-42-0685 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show adral Examiner must be notified at tX Yes 2 No Director NC BEAUFORT Washington 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number with UNITED STATES 27889 326 VAN NORDEN STREET by Funeral within 72 hours after death 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: BLACK 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be 1 permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Florence Wilson Topping Delama Topping 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Temple Hills, Maryland 20748 2900 Oxon Park St. / Son Alphonso Gorham 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State Washington, NC 4 Donation 5 Other (Specify) Pamlico Mem. Gardens 8/30/2008 ☑ Funeral Service Licens € 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signatur 5538 Marlboro Pike Forestville, Maryland 20747 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part L Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably icate has been siç , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was ar performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl o e Son's Resid Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury Naturai 2 Accident Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

completely within 24

State Registrar

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Yea AUG 2 5 2008

one)

1140 Varum Street N.E. Suite 208b Washington, D.C. 20017 Andre Mighalak MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 28585 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year James Louis Goslee 14:35 PM 08 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Wicomico Salisbury 8. Date of Birth
(Month, Day, Year)
Sept. 12,1926 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 XM 2 □ F Months Days Hours Min. Maryland 81 215-20-1698 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Maryland Wicomico Sharptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Main Street 21861 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1951 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1957 1 ☐Yes 2 X No Specify: Yes. Give Specify: 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eddie Lee Goslee Mary Elizabeth Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Goslee/Son P. O. Box 555, Sharptown, Maryland 21861 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sharptown Firemens Cem. 8/23/2008 4 ☐ Donation 5 ☐ Other (Specify) Sharptown, Maryland Name and Address of Facility lier Funeral Home, P. O. Box 207 6 Main Street, East New Market, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 78 CL Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physicien: The law requires that the death certificate be executed 68760. Box P.0. Records, **Division of Vital**

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29b. Signature and title of certifler

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24 hours a completely To the I within 2

State Registrar

31. Date filed (Month

30. Name and a cress of poson who completed cause of death (Item 23a) (Type, Print)

Joseph L. Raffetto, M.D. 1241532V

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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| The state of the s | | rtificat tor, pa | | 25. Was case referred to medical | | | 26 Place of Deat | | | Yes 2 □ No |
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| | 10 # | Within To the | Z | 29b. Signature and title of certifier | | 29c. License | e number | | 29d. Date signed (M | ionth, Day, Year) |
| | | B | | | | D | 57028 | | 08-18 | 80 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | 1/2 | | 30. Name and address of person who completed cause of | death (Item 23a) (Type, | Print) | 73. ^ | t | | |
| State 31. Date filed (Month, Day, Year) 32. Bygistrar's Signature | | Sta | te. | 31. Date filed (Month, Day, Year) 32. Regis | trar's Signature | y Ave IT | dol Anr | rapolis | MD 21 | 401 |
| State Registrar AUG 2 0 2008 State AUG 2 0 2008 State AUG 2 0 2008 State AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 AUG 2 0 2008 | | | | AUG 2 0 2008 | we the | harles | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** J. Hoenstine Harold AUGUST 8 2008 10:22 Å /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY CUMBERLAND MEMORIAL HOSPITAL if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 193-24-3883 04/28/1931 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Bedford Queen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16670 USA 2345 Schellsburg Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dellinger Hoenstine Sarah Jesse မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau
once. Coleen Swartzwelder / Daughter 3181 Black Valley Road, Everett, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenfield Cemetery 108/11/2008 Imler, PA 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signatur, of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMOWARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinitelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 4□Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown COKOWAKY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation

certificate be executed Box 68760, o. م or Vital Records, Division

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

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Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trai signed by the a peen has certificate this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral After t Certification: Medical

2 Accident

3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20066606 08-08-08 OLAIDE A JA41

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

Cumberland, Maryland 21502 Olaide Ajayi MD 31. Date filed (Month, Day, Jear) 900 Seton AUG 1 1 2008

1 ☐ Yes 2 ☐ No

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** A M Valery Havard, III 8 21 2008 1:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/18/1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours tXXM 2□ F 224-40-1069 75 CA Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the therical Examiner must be political at 1 ☐ Yes 2 ▼ No Director Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 46 Battersea Rd. 21811 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐**X**No Specify: Completed by white 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Manager Gas & Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valery Havard, Jr. Anna Burgess 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Mary Lynn Schnader / daughter 46 Battersea Rd., Berlin, MD 21811 Department of Health Important: If item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 8/22/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Suneral Service Licensee Burbage Funeral Home Berlin, MD 21811 108 William St., Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that o used the death. Do not enter the mode of dying, shock, or heart failure. List only one caus Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): inding physician a Ó. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ Ho 24a. Was an 1 ☐ Yes 2 🗔 Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this sion of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manper of Death 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide in 24 hour.
o **the Funeral D**r 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number Name and address of who complete BA 5 State AUG 2 2 2008 Registrar

700:0100

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician AUGUST 28, 2008 1:45P **GRACE** JOY LILLIAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 💢 F 88 219-20-2484 Sept. 29, 1919 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. W. Jicu Evantor, ust be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 United States 412 Grant Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Dillar Guy Clifton Thomas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2161 Archet Lane, Frederick, Maryland 21702 Mark Joy / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 3, 1 N Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Frederick, Maryland 22. Name and Address of Facility Keeney and Basford PA Funeral Home of Funeral Service Lig M01473 106 Fast Church Street, Frederick, Maryland 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1 yours disease or condition resulting in death) /Medical Due to (or s a consequence of): **Examiner** ArrhyThmias Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ■ No Month 5 ☐ Other (specify) o 9 Unknown s been signed by the should be detached 9 Unknown ٥. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mann D 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred I or Attending Paffer death. After Division 5 Pending investigation 1 ☐ Yes 2 🗌 No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Hospital 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK, MD YW WEST 7 Registrar's Signature 31. Date filed (Month, Day, State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0515 AM Jen Kins 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Hospita Prince Georges County Maryland Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-07-1959 9. Birthplace (State or Foreig 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. WASH. 1 □ M 2 🕏 F 220-70-3829 49 DC Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGE'S DISTRICT HEIGHTS MD 10e. Street and Number 10g. Citizen of What Country? 20747 U.S.A. 3705 DONNELL DRIVE permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any jujury or other traumatic event, the Medical Event ODE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PATRICIA DANIELS WALTER JENKINS ပ 19a. Informant's Name/Relationship (Type. Print)
EMMA JENKINS-GRANDMOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 DONNELL DRIVE #204 DISTRICT HEIGHTS, MD 20747 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 In Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY | 8-27-08 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. Kney 524 - 8TH ST., N. E. WASH., DC 20002-5236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 6 HRS Hypotensia disease or condition resulting in death) /Medical Due to (r as a consequence of) Examiner FROM MELTION Diarenhea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan: The law requires that the death certificate be executed signed by the attending physician and lee detached for use as the burial-transit Acute Renaffailure Dehydonnos Unsure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Years Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Ye ar Month Day 5 ☐ Other (specify) 9 \ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20-30% 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of spital or Attending Piours after death.
neral Director: After the filled in by the funera 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred **1.** ■ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospitai 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number - Gecheloton, M.D. DOG 2636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholsonbrown M.D. FELIUA. 1703 SURMATTI 32. Registrar's Signature State Registrar

| | | | | For State Registrar | | Olato c | i iviai j | ylaria | Ce | rtifica | te of L | Death |) | | Reg. No | p. 0 v | | 201 | , , , |
|----------|------------|--|------------------|--|--|--|----------------------------|-----------------------|---------------------|-----------------------|--|-------------------------|--------------------------|---------------------------------------|-------------------------|-----------------|---------------------------|------------------------|-------------------------|
| | | Dhysisi | | 1. Decedent's Name | | | _ | | | | | | | 2. Date of De Month | eath Da | ay | Year | 3. Time | |
| | | Physici: /Medic | al | | Louise | | | | | 4h Cin | , Town, or | Logation | of Doath | Angus | | | of Death | 20 | 91" M |
| | 7 | Examin | er | 4a. Facility Name (If | Memori | | | | | 1 | re de | | | | | | ford | | |
| | | Funeral Director | | 5. Social Security No. 235–58–55 | umber 6. | Sex 1 □ M 2 🖾 F | | ln yrs. Ia | st birthday Yrs. | If Unde Months | er 1 Year Days | If Under Hours | Min. | 8. Date of Bi May 31 | irth ay, Yaar | 37 | 9. Birthp Kent | | or Foreign |
| | | and w | | Usual Residence of 10a. State | Decedent 10b. County | | 10 | Oc. City, | Town or L | ocation | | | | · · · · · · · · · · · · · · · · · · · | | | 1 | 0d. Inside (| City Limits |
| | | Maryla a-f sho | ţor | MD | Harfo | rd | | | Abero | deen | | | | | | | | M XYe | s 2 🗍 No |
| | | death with the Maryland me 23a or 28a-f show must be notified at | Funeral Director | 10e. Street and Nun | | ue | | | | | ip Code 21001 | 1 | | | 10g. C | | What Cour | - | |
| | | Reme ? | uner | 11. Marital Status | | 12. Was Dec | orces? | er in U.S | i. 13. | Was Dec If Yes, sp | edent of H | ispanic O In, Mexica | rigin? (Sp an, Puerto | ecify Yes or N Rican, etc.) | lo- | | ce - Americ ck, White, | | |
| 90 | 980 | within 72 hours after ene. then "naturei", or ite he Medical Exartan | þ | 1 Never Marri | ied 2□ Married 4XXX ivorced | If Yes, G Year or [| 2 🙀 No ive Dates: | | | 1 🗆 Yes | 2 X No | Specify | r. | | | Specif | 'n Whi | te | |
| 804. | 21215-0036 | 72 ho | Completed | (Ѕрес | 15. Decedent's city only highest of | Education rade completed, |) | | 16a. Dec | edent's Us | ual Occupa vork done d use retired | ation during mo | st of work | ing | 16b. | Kind of B | lusiness/in | dustry | |
| 14 | 121 | within iene. then | dmo | Elementary/Seco | ndary (0-12) | College (| (1-4or 5+) | | | stres | | 2) | | | Mai | nufa | cturi | ng | |
| \ | Maryland 2 | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Itam 27 ie markad other then "naturel", or iteme 23a or 28a-f show itam 27 ie markad other then "naturel", or iteme 23a or 28a-f show other traumatic event, the Madical Examiner man be notified at | To Be Co | 17. Father's Name (| (First, Middle, La s Hamilt | | | | | | - | | ner's Nam an Mu | e (First, Middl urphy | le, Maide | n Sumai | me) | | |
| 08 | lary | 2 shou and M ie mar | | 19a. Informant's Na | | | | | | - | ss (Street de | | ber or Rur | al Route Num Aberde | | | , State, Zip | | |
| -36-0 | e, P | 1 and Health tam 27 | | 20a. Method of Disp | gley (Sc | | | 20b. Pl | ace of Disc | osition (N | lame of | 1 | WENTER | Date | | | - City or To | | |
| | ē | Pages nent of nt: if if | | | ☐ Cremation 3 5 ☐ Other (Spe | | State | | metery, cr ford | - | | | 8/30 | /08 | Abe | rdee | n, Ma | rylan | ıd |
| 90 | Baltimore, | permit. Pages 1 and 2 Department of Health a importent: if item 27 is any injury or other tra- | | 21. Signature of Fu | inefils | hisee | | | | Tarr | and Addre | ss of Faci | Fun | eral H | ome, | P.A | . • | | |
| | | 40.244 | | 23a. Part1. Enter ti | he disease, or co | mplications that | caused th | ne death | . Do not e | Aber | rdeen ode of dyin | , Mar ng, such a | ry Lan is cardiac | d 2100 or respiratory | 01-3 arrest, | 399_ | | Approxim Interval B | ate |
| | | Physician | | shock, or hea Immediate Cause disease or condition | rt failure. List on (Final on | ly one cause on | | | 202 | . ~ | | | | | | | | Onset an | d Death |
| U | | /Medical Examiner | | resulting in death) | 1 | aDue to | (or as a | | | | | | | | | | | - | |
| | | | <u>.</u> | Sequentially list concause. Enter Under Cause (Disease or | onditions, | b. Due to | (or as a | cons≱qu | ence of): | | | | | | | | - | | |
| | | ocuted nd transit | Examiner | cause. Enter Under Cause (Disease or that initiated events resulting in death) | 5 | c | | | | | | | | | | | | | |
| | 68760, | The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | | resulting in death) | Lasi | Due to | o (or as a | consequ | ence of): | | | | | | | | | | |
| | 687 | uficate g phys as the | Medical | | | d | | | | | | | | | | | | | , |
| E | Box | eath cer attendin for use | lan/N | IF FEMALE: 23b. Was deceden in the past 12 | | | birth 2 | Fetal | death 3 | | pregnancy | у | | | | | ate of deliv | ery Day | Year |
| -ouis | P.O. I | t the de by the a tached f | Physician/A | in the past 12 1 Tes 2 9 Unknown | No 1 | 4□Preç 9□Unk | nant at tir nown | me or de | eath 5 | Other (| (ѕреспу) | A | | 2 | | | | | |
| 107 | s, P | res that igned b | by Pt | Part II. Other signi | ficant condition | s contributing to | death but | not resu | Ilting in the | underlying | g cause giv | ven in Par | t I. | | | | | the cause of | |
| E | ord | w require been si should b | eted | 2654 | he > | > hoc | <u> </u> | | | | | | | | Yes | _ | - | | Unknown |
| 五 | Record | The law cate has b | Completed | 2 Mp | horse | 7-7 | | | | | | | | pe | topsy rformed | ? | death? | | s available cause of |
| EMFI | Vital | | 60 | 25. Was case refer | rred to medical | | | | | | | 26. Pla | ce of Dea | th <i>Check</i> on | 2 Д () У опе) | No | 1 🗆 Yes | 2 🗆 No | |
| 7 | oţ. | Physician: this certific | To B | examiner? 1 ☐ Yes 2 ☑ | | | | - | ER/Outpat | | | | Nursing H | ome 5□Re | | | | ity) | |
| E | | | Hon: | 27. Manner of Deal | .fh 5 ☐ Pending investiga | | e of Injury onth, Day | Year) | 28b. Time Injury | | 28c. Injui Wo | ryat rk?]Yes 2[| □No | 28d. Describ | e how in | ijury occi | ıııed | | |
| 48 | Division | f or Attending after death. Director: After in by the fune | Certification; | 2 Accident 3 Suicide 4 Homicide | 6 Could no | t be 28e. Plac | ce of Injur Iding, etc. | y - At ho (Specify | me, farm, | street, fact | | | | 28f. Location City or 1 | n (Street Town, St | and Nun ate) | nber or Rui | rai Route N | um <i>ber,</i> |
| Z | | To the Hospital o within 24 hours at To the Funerel Di completely filled in | ledical Co | 29a. Certifier (Check only one) | | Physician: To the caminer: On the and ma | | xamina | | | | | | | | | | | Θ(s) |
| | | To the vithin To the comple | Be | 29b. Signature and | d title of certifier |) | | | | : | 29c. Licens | se numbe | or | | 29d. 1 | Date sign | ned (Month | . Day, Year | -) |
| | | | | 20 | Jon | 1000 | | 17 | D | | Do | 005 | 35 | 68 | An | a us | +21 | 6,20 | 800 |
| | | | | 30. Name and add | lress of person w | h completed ca | | | | e, Print) | | 201 | u. | de 1 | A. | معلوا | - N | 9 - — 1 | |
| | | St | ate | 31. Date filed (Mor | nth, Day, Year) | 32, | Registrar | 's Signa | | - () · | | TA | -16 | | 40 | ec. | | ~ 7 | 21078 |
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| n . | DI | HMH 17 Rev 1/ | 2001 | | ٠ | ~ | | | The same | | | | | | | | | | |

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) Aug. 14, 2008 **Physician** Kutina 11:29aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **№** M 2 🗆 F Months Days Hours 585-74-8465 84 Director Czechoslovakia 7/23/1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examinar must be notified at MD Montgomery Kensington 1 ☐ Yes 2 X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 3000 McComas Avenue 20895 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or iter any injury or other traumatic event 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛂 No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5 + Elementary/Secondary (0-12) American University Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jan Kutina Amalie Tauberova 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipp 1 F.4 19a. Informant's Name/Relationship (Type. Print) Irena Gigiel-Daughter 6 Mayall Avenue Toronto, Ontario, Canada 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removation State Chesapeake Crem. 8/18/2008 Beltsville, Md 4 Donation 5 ☐Other (Specify) 21. Signature uneral Service License P部上型 Address of TNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 Approximate Interval Between Onset and Death 2days 23a. Part 1. Enter the dis ** se, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fails re. List only one cause on each line. Immediate Cause (Final Pneumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a P.O. 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown Failure to thrive 24b. Were autopsy findings available prior to completion of cause of death? Dementia, Chronic atrial fibrillation 24a. Was an Chronic leg ulcers 1 □Yes 2 XNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number è how du D43121 August 15,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md 20910 Chowdury Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day August 18, 2008 **Physician** 8:50pm M Chen Dar Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Sept. 8, 1919 Director 88 China 214-96-2229 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Examinat must be notified 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a 192 Hardy Place United States 20852 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Lee Unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2: nent of Health a Hsiu Lee (Daughter-in-law) 33 Brassie Court, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/20/08 Alexandria, Virginia 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Euneral Service Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C e (Final ndition resu ting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner Metastatic Lung Adenocarcinoma Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed physician and the burial-transi Pleural Effusion resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Pericardial Effusion attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Pneumonia Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? aw autopsy performed? 1 Yes 2 No certificate 1 ☐Yes 2 ☐No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 X Natural Injury 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 19, 2008 D0064478 30. Name and addres even on we completed cause of death (Item 23a) (Type, Print) Fisehatsion Mehari, M.D., 9901 Medical Center Drive, Rockville, MD 20850 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

28594

| 1 | |
|---|-----------|
| | Physician |
| | /Medical |
| | Examiner |
| | |
| | |

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| ľ | Stete Registr <i>a</i> r | | | | Cei | rtificat | e of L | Death | | F | Reg. No. | 2000 | J | 2000 | , 7 |
|-------------------------------|---|--------------------|---|--------------------------------------|--------------------------------|----------------------------|-------------------------|---------------------------|----------------------|---------------------------------------|--------------------|---|-------------------|---|---------------|
| | 1. Decedent's Nam | ne (First, Midd | fle, Last) | | | | | | | 2. Date of Dea | | | | 3. Time of Deat | th |
| n | MARY | 1 | Е. | LI | TTLE | | | | | AUGUST | Day 29 | | 7 | 9:50 A | М |
| al - | 4a. Facility Name (| | on, give street and nu | | | 4b. City. | Town, or | Location | of Death | MOGOSI | | County of De | ath | 9:30 A | |
| r | | | ALTH AND F | | ΓΔΤΤΩΝ | | | HILL | | | | HARFO | | | |
| Q. | 5. Social Security | | 6. Sex | 7. Age (In yrs. I | | If Under | | If Under | 24 Hrs. | 8. Date of Birt | h | | | ace (State or For | reion |
| | 179-20-8 | | 1 □ M 2 🙀 F | 86 | Yrs. | Months | Days | Hours | Min. | (Month, Day 10/29/ | v. Year) | (| Count | ry) | eigii |
| | Usual Residence o | | 1 | 00 | | | | | | 10/29/ | 1921 | IVI. | ary | rland | |
| | 10a. State | 10b. County | v | 10c. City | , Town or Lo | cation | | | | | | | 10 | d. Inside City Lir | mits |
| 5 | MD | Harf | • | 1 | Whitef | ord | | | | | | | | 1 Yes 2 X | |
| ect | | 1 | | | | | | | | | 40. 07 | | | | |
| | 10e. Street and Nu | | | _ | | 10f. Zip | Code | | | | 10g. Citi | zen of What (| Count | try? | |
| ro | 1225 OT | a Pyres | sville Roa | ad | | | | 21160 | | | | USA | | | |
| ne | 11. Marital Status | | 12. Wes Dec | cedent Ever in U. | S. 13. | Was Deced | dent of H | ispenic Or an. Mexica | igin? (Sp | ecify Yes or No- Rican, etc.) | . | Race - Ar Black, WI | | | |
| ĭ | 1 🗌 Never Mar | ried 2□ Ma | rried 1 ☐ Yes If Yes, G | 2□ M o | | 1 ☐ Yes | | Specify: | | , , | | | | | |
| Completed by Funeral Director | 3 j∑ Widowed | 4 Divorce | d Year or I | Dates: | | | | - Opeony. | | | | Specify: W | ודנ | .e | |
| š | (Sne | 15. Decede | nt's Education est grade completed |) | 16a. Dece | dent's Usua | al Occup | ation | et of work | ina | 16b. Ki | ind of Busines | ss/Ind | ustry | |
| <u>ğ</u> . | Elementary/Sec | | | (1-4or 5+) | | kind of wo DO NOT us | | d) | , 0, 110111 | ,9 | _ | | | | |
| Ö | 9 | | <u> </u> | | Home | maker | · | | | | O | wn Home | e | | |
| Be C | 17. Fether's Name | | | | | | | 18. Moth | er's Nam | e (First, Middle, | Maiden | Surname) | | | |
| ToB | William | Hopkir | ns | | | | | Lau | ra Ri | noades | | | | | |
| _ | 19a. Informant's N | lame/Relation | ship (Type. Print) | | 19b. Mailir | ng Address | (Street | and Numb | er or Rui | rai Route Numbe | er, City o | or Town, State | e, Zio | Code) | |
| | Lee I. | | | | | | | | | oad, Whi | | | | 21160 | |
| | 20a. Method of Dis | | | 20b. P | | | | | | Date WIII | | ocation - City | | | |
| | 1 → Burial 2 | ☐ Cremation | 3 ☐Removal from | 1 State | lace of Dispo emetery, crea | | | | | | 200. LC | ocation - Oity | 01 10 | WII, State | |
| | 4 ☐Donation | 5 Other (| Specify) | Be. | l Air | | | | | 2008 | Be. | l Air, | MD |) | |
| | 21. Signature of F | uneral Service | e Ligensee | | | 2. Name ar | | | - | _ | | | | | |
| | Whele | es P. | Woveles | 2 | | | | | | ne, Inc. | , De | elta, E | PA. | 17314 | |
| | 23a. Part1. Enter | the disease, o | or complications that st only one cause on | caused the death | n. Do not en | ter the mod | le of dyir | ng, such as | cardiac | or respiratory a | rrest, | | | Approximate Interval Between | 0 |
| | Immediate Cause | (Final | only one causa on | of low is | 2-11-1 | 100 | de | RAI | 0 | | | 0 | 0 | Onset and Deat | |
| | disease or condition resulting in death) | on | a. Duo to | /or or o consequ | 10000 00: | COV | 00 - | | | | | | | years | |
| | | | Due it | (or as a consequ | uence of): | . L | , | 1 | A . | | | < | 7/1 | 1, | |
| _ | Sequentially list co | onditions, | b. Due to | (or as a consequ | lende of): | 114 | 7 | | | 2 | | | 4 | 7- | |
| Medical Examiner | cause. Enter Und Cause (Disease o | envina | 4 | 1 | 1 | | - 1 | | | | | (, | 1 | | |
| ап | that initiated event resulting in death) | S | c | IL LE | 0, | | - 1 | | | | | | 1, | 7 | |
| Ω — | , resulting to death, | | Due to | o (or as a consequ | uence or): | | | | | | | | | / | |
| ca | | | d | | | | | | | | | | + | | |
| <u>Jed</u> | IE EENALE. | | | | | | | | | | | | | | |
| | IF FEMALE: 23b. Was deceder | nt pregnant | 23c. If yes, o | utcome pf pregna | ncy | ⊒Ectopic p | roanana | , | | | | 23d. Date of | delive | ery | |
| <u> </u> | in the past 12 | | 4□Preg | birth 2 ☐ Feta gnant at time of d | | ⊒Ectopic pi ∃ Other (s¢ | | / | | | | Month | | Day Year | |
|)ys | 1 ☐ Yes 2 9 ☐ Unknow | n | 9□Unk | nown | | | | | | | | | | | |
| Completed by Physician | Part II. Other sign | ificant condit | tions contributing to | death but not resi | ulting in the u | inderlying c | ause giv | en in Part | 1. | 23e. Did t | obacco | use contribute | to th | e cause of death | 1? |
| 5 | al- | , her | ner 's | | | | | | | 1 🗆 ' | Yes 2 | No 3□ | Prob | ably 4 □Unkn | nown |
| že | | 5 | 0 | | | | | | | | | | | | |
| 풫 | | | | | | | | | | 24a. Was | | 24b. Were | autor to cor | psy findings avail npletion of cause | lable e of |
| ő | | | | | | | | | | | rmed? | death | 1? | 2□ No | |
| Bec | 25. Was case refe | erred to medic | al | | | | | 26. Plac | e of Deat | th (Check only o | /4 | | | | |
| 0 E | examiner? 1 ☐ Yes 2 | No | Hospital: 1 | Inpatient 2 | ER/Outpatier | nt 3 DC | OA Oth | | | ome 5 Resi | | 6 □Other /S | pecifi | v) | |
| | 27. Manner of Dea | | 28a. Date | e of Injury | 28b. Time o | | 28c. Injui Wor | | | 28d. Describe | | _ | (۱۱۰۰ م | | |
| 0 | 1 Natural 2 Accident | 5 ☐ Pendi inves | ing (Mo | nth, Day Year) | Injury | м | | ńk? Yes 2.⊡ |]No | | | | | | |
| <u>ca</u> | 3 ☐ Suicide | 6 ☐ Could | d not be | ce of injury - At ho | me. farm. st | reet factor | | | | 28f Location (| Street au | nd Number or | Rura | I Route Number, | |
| Ē | 4 Homicide | deter | mined 200. Flac | ding, etc. (Specif | y) | | ,, | | | City or To | wn, State | e) | riuiu | rriodic rambol, | |
| <u>ಪ</u> | ODo Codiffee | 1000 | ing Physicis - T. " | a boot of multi- | wlodes de l' | th accurre | nt th - " | mo | and aller | and due to the | 22.2.7 |) and :: | | 104-d | |
| Medical Certification: To | 29a. Certifier (Check only | 2 ☐ Medica | ring Physician: To the al Examiner: On the | besis of examina | wieage, aeat tion and/or ir | n occurred ovestigation | at the ti n, in my (| me, date a opinion, de | na place ath occu | , and due to the rred at the time, | cause(s date an | i) and manner id pl <i>a</i> ce, and (| r as si due to | tated. the cause(s) | |
| ed | one) | A | and ma | nner stated. | | | | | | | | | | | |
| 2 | 29b. Sighature an | dittle of denti | ier () () | | | 29 | c. Licens | e number | 39 | | 29d. Da | ite signed (Mo | | | |
| | Xnd | 6 Ct | ul | | | () | C0 | 7 | - ' | a | AUS | T 29 | , 2 | 2008 | |
| | 30. Name and add | ress of perso | n who completed car | use of death (Iten | 23a) (Type. | Print) | | | | | | \ | ı. | | |
| | | . 1 | ICH - 101 | | | , | ET. Δ | TR. N | m 21 | 014 | | | | | |
| e. | 31. Date filed (Mo | | | Registrar's Signa | | | uu A | E | 41 س | . 017 | | | | | |
| e Ir | | P052 | | سک | 1 | 45 | | | | | | | | | |
| | V- | . 00 6 | LUUU ANDRON | 43.0 | A STATE OF | | | | | | | | | | |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death onth Day AUG 20 2008 **Physician** ANNA LEARDINI-NORWOOD 12:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🕅 F May 18, 1945 Italy Director 63 228-78-6802 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 No Directo Italy Vicenza Camisano 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 Italy Via S. Daniele 13R 36040 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief of Accounting Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Lorenzi Dino Leardini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unit 31401 Box R 8069 APOAE 09630 Alva Norwood, Jr., Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or othe Riverdale Park AUG. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Riverdale Park, MD Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thibadeau Mortuary 933 Gist Ave., LL, Service, P.A. Silver Spring, Brim Mi Plan M01508 MD20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC BREAST CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2⊠No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2및 No 1 🗆 Yes 2**K** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 ₩ Natural 2 Accident 1 ☐ Yes 2 ☐ No after death in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature

31. Date filed (Month, Day, Year)

AUG 21

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEREE B. SAUNDERS 2 Registrar's Signature 2008

MC

USN

LT

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

29c. License number

D-65033

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

CINTER

Physician Examiner

the

signed by

has

After this

after death

e Funeral I

within 2

Hospital or Attending Physician:

2

Completed

Be

Certification: To

Medical

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Dav Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐Yes 2 ☑No 26. Place of Death (Check only one)

08/21/2008

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

t certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier mn

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAE T, AUNG, 24435 MPR DEAN RD. HOLLYWOOD MD 20636 MERVELL

State Registrar 31. Date filed (Month, Day, Year) AUG 2 5 2008

32. Registrar's Signature

| 08-06637 | |
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| llen Leon Linde | | 1- For State | ate of Maryl | | artment of rtificate of | | and | Ment | al Hy | | 2. No. 2 | 00 | 8 2859 |
|--|----------------|---|-----------------------|-----------------------------|----------------------------|------------------------------------|----------|----------------------------------|------------|---------------------|----------------------------------|-------------------|---|
| Physicia | | Registrar 1. Decedent's Name (First, Middl | e,Last) | | | - | | | 2 | . Date of Death | | | 3. Time of Death |
| ledical Exami | ner | Allen Leon Li | | | | | | | | Month August 30, | 2008 | | 1101 hrs |
| | | 4a. Facility Name (if not institutio 8213 Pulaski Highway | | umber) | 4 | b. City, Town Rosedal | | ocation of | Death | | 4c. County Baltimo | | nty |
| Funeral | | Social Security Number | 6. Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 | Year | If Under | 24Hrs. | 8. Date of Birth | (MM/DD/YYY) | g. Birth | place (State or |
| Director | | 184-52-1107 | 1 X M 2 F | | 48 Yrs. | Months | Days | Hours | Min. | 09/04/ | 1959 | Cou | Pennsylvan ntry) |
| | | Usual Residence of Decedent | | | | | | | | | | | |
| w an | | 10a. State 10b. County | | | Town or Location | | | | | | | | 10d. Inside City Limits 1 Yes 2 X No |
| Maryland 28a-f show any | ģ | Maryland Cec | i1 | C | onowing | O 10f. Zip Co | do | _ | | I 10 | g. Citizen of W | hat Coun | |
| ith the Maryland 23a or 28a-f sho | Director | 11 Campbell | Court | | | | 1918 | 3 | | 10 | U.S | | .,, |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once | | 11. Marital Status | | cedent Ever in U | | Decedent of | of Hispa | anic Origi | | cify Yes or No- | 14. Race | e - Americ | an Indian, Black, |
| death r item | Funeral | 1 Never Married 2 X M | arried Armed F | orces? | If Ye | es, specify C | uban, I | Mexican, | Puerto R | Rican, etc.) | Whit | e, etc. | |
| after aff, o | by | | orced If Yes, Give Ye | | | Yes 2 X | | | | N. | Specify: | | |
| hours natur Exam | | 15. Decedent's Education (Spe Elementary/Secondary (0-12) | | 1-4 or 5+) | 16a. Decedent | t's Usual Oct ost of working | | | | | 16b. Kind of B | | |
| 36 nin 72 fhan dical | ble | 12 | College | 1-4 or 5+) | Pain | ter | | | | - | Contr | - | - |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica | Completed | 17. Father's Name (First, Middle, | Last) | | | | 18 | 8.Mother's | s Name (| First, Middle, M | | | |
| 1218 be fill sntal H rrked | Be | Allen Linderm | an, Sr. | | | | | | | Henry | | | |
| O 21 should nd Me is ma | ٩ | 19a. Informant's Name/Relations | | | | , | | | | ıral Route Num | = | | _ ' |
| Baltimore, MD 21215-0036 bernit Pages I and 2 should be filed within 72 hor bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na njury or other traumatic event, the Medical Ex | | Deborah Linde 20a. Method of Disposition | rman/Wife | | Place of Dispos | | _ | | , (| onowing Date | 20c. Location | 2191 - City or | |
| ges L. r. f. f. f. f. f. f. f. f. f. f. f. f. f. | | 1 X Burial 2 Cremation | n 3 Removal | from State | crematory or oth | er place) | | | | 0.40000 | | | |
| Baltimo permit. Page Department of Important: injury or ott | - | 4 Donation 5 Other Si 21. Signature Funeral Service | | Fa | irview_ | ame and Add | dress c | of Facility | | 3/2008 | | VILLE | e, PA |
| Ba Perm Depr | | | WALA | | l R | .T. Fc | ard | 1 Fur | nera i | l Home, | P.A. | ID 2 | 1911 |
| Physician | | 23a. Part. Enter the disease, or failure. List only one cause | complications that | caused the death | n. Do not enter th | ne mode of d | ying, s | uch as ca | ardiac or | respiratory arre | st, shock, or he | eart | Approximate Interval Between Onset and |
| /Medical xaminer | | Immediate Cause (Final disease | a. Narco | tic into | | n | | | | | | y. | Death |
|) | | or condition resulting in death) | Due to (or as | a consequence o | of): | | | | | | | | |
| | ĕ | Sequentially list conditions, if any, leading to immediate | | a consequence o | of): | | | | | | | | |
| | Examiner | Disease or injury that initiated | c | a consequence of | of). | | _ | | | | | | |
| uted Id ransit | | events resulting in death) Last | ď | | | | | | | | | | |
| ox 68760, eath certificate be executed attending physician and ior use as the burial - transi | dical | X UNPENDED | X AMENDED | #1,23a, #1 per | PII,27, | 28a-f | b oP/ | erME | r g88 | 84 10/3 | /08 TT | | |
| 760, cate b | /Mec | IF FEMALE: | 23c. If yes | , outcome of preg | gnancy | 14 10/. | - 77 | | | | 23d. Date of | | |
| Box 68760 death certificate the attending physical for use as the blue | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | I LIVE | birth nant at time of de | noth | tal death ner <i>(Specify</i> , | 3 _ | Ectopic | pregnar | ncy | Month | | ay Year |
| Box e death the atte | ysi | 1 Yes 2 No 9 Un | known | nown | 3 01 | ner (Specify) | _ | | | | | | |
| · a ra | by P | Part II. Other significant condit | tions contributing | to death but not r | resulting in the u | nderlying ca | use giv | ven in Pa | rt I. | | | | the cause of death? |
| ords, P.C | ed b | Cocaine use | | | | | | | | 1 Yes | | | topsy findings available |
| cords law requi | plet | | | | | | | | | autop perfor | sy | | ompletion of cause of |
| tal Rec | Completed | | | | | | | | | 1 🗸 Yes | | 1 ✓ Ye | s 2 No |
| of Vital Records, P.O ng Physician: The law requires that to the this certificate has been signed by meral director, page 2 should be detaa | Be | 25. Was case referred to medica examiner? | Hospital: | In-ations 2 | ED/Outretient | | - 10 | of Death (Other ₂ | _ | | Residence 6 | Othor | · Scone |
| of Vit ding Physic After this funeral dire | 2 | 1 Yes 2 No 27. Manner of Death | ' | Inpatient 2 e of Injury | ER/Outpatient | | , | at Work | | 28d. Describe | | | . Scene |
| ion c tending eath. tor: Af the fun | ţį | 1 Natural 5 Pen | ding Fnd | th, Day,Year) 8/30/08 | Fnd 11 | :00 an | Ye | es 2 X | No | unk | | | |
| Division tal or Attendii 15 after death. 18 Director: A | Certification: | V | stigation | ice of Injury - At h | nome, farm, stree | | | ilding, et | c. | | | | ral Route Number, City |
| Divisi pital or At ours after d neral Direct filled in by | Sert | 4 Homicide dete | rmined (Specif) | ,) M | lotel | | | | 1 | Rm 122 | Riverda | ile, | ski Hwy. |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: | | 29a. Certifier (Check only one) Certifying P Medical Exa | hysician: To the be | est of my knowled | dge, death occur | red at the tin | ne, dat | e and pla | ice, and o | due to the caus | e(s) and manne and place, and | er as state | ed. e cause(s) |
| To the To the comp | Medical | 29b _A Signature and title of certific | and manner | stated. | | | | number | | | | | nth, Day, Year) |
| | = | Mouse A | h . C. Mar | 10 | | | D.C.N | | | | August 3 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| | | 30. Name and address of person | who completed ca | use of death (Iten | n 23a) | | | | | | | | |
| | | Margarita Korell MD. | | edical Examir | | enn Stree | t, Ba | ıltimore | , MD 2 | 21201 | | | |
| St | ate | 31. Date filed (Month, Day, Year) | 32. F | Registrar's Signat | ture | 1. 1 | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006 ORIĞINAL

| | | | For State | State of Maryland | | artment of H rtificate of L | | lental Hyو | giene Reg. No. 2 (| 108 | 28598 |
|----------|---|------------------|--|--|-----------------------|---|-----------------------------|--|---------------------------------|--|--|
| * 10 | | | Registrar 1. Decedent's Name (First, Middle, Last, |) | Oei | tillcate of L | Jean | 2. Date of Dea | ath | | 3. Time of Death |
| | Physicia /Medic | - | | Kenzie | | | | July | 20 ^{Day} 200 | | 6:15p м |
| | Examin | er | 4a. Facility Name (If not institution, give | | | 4b. City, Town, or | ma Park | | | y of Death | rv |
| E | Funeral Director | | Washington Adve 5. Social Security Number 6. Se 212-68-2800 12 | | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Da 2/12/ | h y, Yea <i>r</i>) | 9. Birthpi Coun | lace (State or Foreign |
| ī | and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| | Maryl a-f sho ified a | tor | MD Montgome | ery Ta | koma | Park | | | | | 1 XYes 2 No |
| | th with the 23a or 28 st be not | Funeral Director | 10e. Street and Number 6801 Westmore | and Avenue | | 10f. Zip Code 20 | 912 | | 10g. Citizen of USA | What Coun | atry? |
| -0030 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | þ | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | Was Decedent of Hi If Yes, specify Cuba 1፟∑Yes 2☐ No | | ecify Yes or No Rican, etc.) ban | Bla | ice Americ ack, White, ify: Bla | etc. |
| 10-CI Z | ithin 72 hor nan "natura Medical E | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | cation le completed) College (1-4or 5+) | (Give life. | dent's Usual Occupa kind of work done of DO NOT use retired | during most of work l) | ing | 16b. Kind of I | | dustry |
| וס סו | filed w Hygier other th | e Cor | 10 17. Father's Name (First, Middle, Last) | | Ma | aintenan | 18. Mother's Name | e (First, Middle, | | | |
| Ian | uld be Mental Irked o | To Be | Victor McDonal | Ld | | | Irene | McKenz | ie | | |
| Mar | 12 should the and Men 7 is marker traumatic | | 19a. Informant's Name/Relationship (7) Jeannette Rodr: | | | ng Address <i>(Street a</i> | | | | | Code) Park, MD |
| a) | es 1 and of Healt fitem 2 r other | | 20a. Method of Disposition | 20b. Pl | lace of Dispo | osition (Name of matory or other place | ce) | Date | 20c. Location | - City or To | 20912 own, State |
| Saitimor | Pages Iment of I Iant: If its jury or o | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | Ga | te of | f HEaven | 8/22 | /2008 | | | Spring, Md |
| pall | permit. Page Department of Important: If any injury or | | 21. Signature of Funeral Service Cert | ac' | | 2. Name and Addres HILIP D. | | | | | A.P.A. Md20910 |
| į. | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused the death ne cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Physician / /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a consequ | Jence of): | MACI | TOF | ttis | 3~ | | |
| | Examiner | | Sequentially list conditions | · RESPE | nA | Tony | TAN | ue | E | | |
| | nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due (r as a consequ | ience of): | ,o~/s | Die | 150 | 5 | | |
| Ď | cate be executed physician and s the burlai-transit | I Exa | resulting in death) Last | Due to (or as a consequ | uence of): | -n 0 3 n | ouksa | 11 A-1 | Arc | A DE | NT |
| 98/PU | | edical | | d. / Cure | | به ال | - | AUT C | 0 (00 | | |
| O. BOX | the death certific y the attending p | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome pf pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown | Ideath 3 | ⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> | <i>y</i> | | | Date of deliv Month | ery Day Year |
| rds, P | The law requires that the dite has been signed by the age 2 should be detached | by | Part II. Other significant conditions or | ontributing to death but not resu | ulting in the u | underlying cause giv | en in Part I. | | | | the cause of death? |
| Hecord | The lan ate has page 2 | Completed | | | | | | 24a. Was auto perf 1∐ Yes | an 24l psy ormed? 2 No | o. Were auto prior to co death? 1 ☐ Yes | opsy findings available ompletion of cause of |
| Vital | Physician: r this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | ED/O tratia | -t 2000 Oth | 26. Place of Dea | | | | 77.1 |
| on or | ng Phy fter this neral d | tion: To | 1 | 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | of 28c. Injui | 4 ⊔ Nursing H | ome 5 ☐ Res 28d. Describe | how injury occ | | ny) |
| DIVISION | al or Attending s after death. al Director: Afte ed in by the fune | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of injury - At ho building, etc. (Specify | ome, farm, st | treet, factory, office | | 28f. Location City or To | (Street and Nui wn, State) | mber or Rui | al Route Number, |
| | To the Hospital or After within 24 hours after des To the Funeral Directo completely filled in by the | Medical (| | ysician: To the best of my kno niner: On the basis of examina and manner stated. | | | | | | | |
| | To the vithing to the complex | Ž | 29b. Signature and title of contifier | ~ Mi | ,6- | 29c. Licens | se number | 77- | 29d. Date sig | ned (Month | , Day, Year) |
| , | ţ | (| 20. Name and address of pareon who | completed cause of death intern | 23a) (Type | Print) To | Anon | A C | Sur. | , m. | > |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) AUG 2 1 200 | Registrar's Signa | ature | and in | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #23(a) per phy., trw, 08/14/08, State of Maryland / Department of Health and Mental Hygiene Allegany Co. Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13, 2008 12:20 P.^M ROBERT В. McKENZIE AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 19007 SLOAN AVENUE, S.W. FROSTBURG ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Social Security Number **Funeral** Days Months 213-24-5270 AUG. 29,1928 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show the must be notified at 1 ☐ Yes 2 X No MD ALLEGANY FROSTBURG Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 U.S.A. 19007 SLOAN AVENUE, S.W. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🌠 No If Yes, Give 1 Never Married 2 Married "natural", or li edical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) KELLY-SPRINGFIELD Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER TIRE COMPANY permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If item 27 is marked other thi any Injury or other traumatic event, the once. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL B. MCKENZIE EMMA CROFT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15504 WINSLOW STREET, S.W., CUMBERLAND, MD 21502 PAUL D. WILSON / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State FROSTBURG MEML. PARK 08/16/2008 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 21502 202 GREENE STREET, CUMBERLAND, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End stus /Medical Due to (or as a consequent of): Examiner Progressive Uremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a ld be detached for 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician:

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral (To the Hospital
within 24 hours a
To the Funeral L

10 State Registrar 29a. Certifier

29b. Signature and title of certifier

Medical

925 WONSOCK SHIN 32. Registrar's Signature 31. Date filed (Month, Day, Year)

4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BISHOP

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00055325

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner**

Funeral

Director

death with the Maryland iral", or items 23a or 28a-f shov Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene, "natural" d other than "natu event, the Medical

altimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed attending physician and I for use as the burial-trai the To the Hospital or Attending Physician: this Bruneral Director etely filled in by t

Division or Vital Records, P.O. Box 68760,

06:35 AM M Raymond C. Mannick, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany 10022 Parkersburg Road, N.W. Frostburg 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Yrs 52 Maryland 213-76-1848 August 18, 1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Allegany Frostburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10022 Parkersburg Road, N.W. 21532-U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 🜠 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) loader operator concrete manufacturer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Rephann Raymond C. Mannick, Sr. မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Cindy Mannick 10022 Parkersburg Road Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State August 11, 2008 **Cumberland Crematory** Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee John 1 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final metastatic 18 mos melanome. disease or condition resulting in death) Due to (or as a consequence of): involveni. Metadoan LABOR 18 ma BRain Sequentially list conditions, many leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Legans INVolvent 18 m metadas Liver Due to (or as a consequence of): SBW. MELLINOM mollywant Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ HYPOSHYDOIDUSM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERMENDIN Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypinlipidenia. 24a. Was an autopsy performed ASTHMA / CORD 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Cent Nolsy md D0065518 8/11/08 manego 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 621 Kelly Road, Comber and MD 21502

Registrar

State

MARILYN

AUG 1 2 2008

31. Date filed (Month, Day, Year)

MK NELOON MID

egistrar's Signature

| | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death | | | | | | | 3. Time of Death | |
|---|-------------------|---|---------------------------------------|---|------------------------|---|-----------------------------------|---|---------------------|--|
| Physician | | | | | | | AUGUST 9, 2008 | | 3:00 A ^M | |
| /Medical | | MAJOR FLMO McCOY 4a. Facility Name (If not institution, give street and number) | | | 4b. City. Town, o | r Location of Death | | 4c. County of Death | | |
| Examiner | | 8633 Vast Road Drive | | | Colu | | | HOWARD | | |
| Funeral | | 5. Social Security Number 6. Sex |) If Under 1 Year | If Under 1 Year If Under 24 Hrs. 8. Date of E | | | place (State or Foreign intry) | | | |
| Director | | 5. Social Security Number 6. Sex 1 Security Number 499-16-8709 1 Sept. 29, 1912 95 Yrs. 1 Sept. 29, 1912 Ax | | | | | | rkansas | | |
| | | Usual Residence of Decedent | | | | | | | | |
| ylanc how | | 10a. State 10b. County | ocation | | | | 10d. Inside City Limits | | | |
| r 28a-f show | Director | MD Howard C | | | olumbia | | | 1√Yes 2□N | | |
| or 28 | jre | 10e. Street and Number | 10f. Zip Code | | | 10 | 10g. Citizen of What Country? | | | |
| th wit | al | 8633 Vast Roa | 21045 | | | | U.S.A. | | | |
| items | Funeral | 11. Marital Status | 2. Was Decedent Armed Forces? | Ever in U.S. 13 | . Was Decedent of I | Hispanic Origin? (Span, Mexican, Puerto | pecify Yes or No- Rican, etc.) | 14. Race - Amer Black, White | | |
| after or ite | /FL | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No | | | 1 □Yes 2 □ No Specify: | | | Specify: Black | | |
| hours after death with the Maryland tural", or items 23a or 28a-f show at Expedition mast be notified at | d by | 3 X Widowed 4 □ Divorced | | | | | | | | |
| 72 h "natu | Completed | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired) | | | | | | ndustry | | |
| vithin | m d | Elementary/Secondary (0-12) | College (1-4or 5 | i+) | | , | | Agricult | 1120 | |
| lled v Hygie ther t | ပိ | 17. Father's Name (First, Middle, Last) | _5+ | Agr | cultue | | e (First, Middle, M | | .ure | |
| l be f ntal l ed of | Be | Jessie McCoy | 7 | | | | my Lee 1 | | | |
| hould d Me nark natic | ို | 19a. Informant's Name/Relationship (Typ | | 10b Mai | ling Address (Street | | | | in Code) | |
| d 2 sl th an 7 is i | | | | | 0632 T/2 | Road | Dr C | City or Town, State, 2 Dlumbia, | MD 21045 | |
| 1 an Heal em 2 | | Marjorie B. McC | Joy (Dat | ighter) | position (Name of | 1 | | Oc. Location - City or 1 | | |
| ages nt of :: If it | | Buria 2 Cremation 3 R | emoval from State | cemetery, cr | ematory or other pla | | /16/08 | Pine Blu | iff AR | |
| it. Pre rtme rtant | | 4 □ Donation 5 □ Other (Specify) | | Cypres | 32 Name and Addr | CEMI 0 | NOMDEN | FUNERAL E | IOME, P.A. | |
| permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, I'm Medical once. | | 21. Signature of Funeral Service License | Shan | | | | | ockville, | | |
| | | / luge | JIWW | The Thin | | | | | Approximate | |
| | | shock, or heart failure. List/only one cause on each line. | | | | | | | | |
| Physician | | Immediate Cause (Final disease or condition resulting in death) | | nary Ar | tery Dis | ease | | | | |
| /Medical Examiner | | Toolsing in doding | , | a consequence of): | | | | | | |
| | 7 | Sequentially list conditions, if any, leading to immediate b. <u>Hypertension</u> Due to (or as a consequence of): | | | | | | | | |
| ted sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequence on. | | | | | | |
| executed in and ial-transit | xar | Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| icate be executed physician and the burial-transit | | | | | | | | | | |
| certificate be nding physicia ise as the bur | an/Medical | 0 | | | | | | | | |
| ath certific attending p for use as f | /M | IF FEMALE: | 3c. If yes, outcome | | | | | 23d. Date of del | ivery | |
| leath atte | cia | 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month | | | | | | | Day Year | |
| the c y the | Physici | 1 Tyes 2 No 9 Unknown 9 Unknown | | | | | | | | |
| that ned b | y P | Part II. Other significant conditions con | tributing to death b | ut not resulting in the | underlying cause gi | ven in Part I. | 23e. Did tob | acco use contribute to | the cause of death? | |
| puires n sign lld be | d by | Adult Failure to Thrive Syndrome | | | | | 1 ☐ Ye | s 2 □ No 3 □ Pr | obably Management | |
| w rec | Completed | | | | | | 24a. Was an | Vas an 24b. Were autopsy findings available | | |
| he la e has ge 2 | ᄪ | | | | | | | psy prior to completion of cause of death? | | |
| n; T ificat or, pa | | | | | | | | | 2 🗆 No | |
| sicla s cert irecto |) Be | 25. Was case referred to medical examiner? Hospital: Hospital: Other: A Desidence of Death (Check only one) | | | | | | | | |
| Phy er this eral d | Certification: To | 1 Yes 2000 Tospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outer 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred | | | | | | | ony) | |
| ding th. Afte fune | tior | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da | y, Year) Injury | / Wo | rk?]Yes 2 □ No | | | | |
| Atten deal ctor y the | fica | 3 Suicide 6 Could not be | 28e. Place of Inj | ury - At home, farm, s | | eet, factory, office 28f. Lo | | ation (Street and Number or Rural Route Number, | | |
| after Dire | erti | 4 Homicide determined building, etc. (Specify) | | | | | City or Town, State) | | | |
| spita nours neral | | 29a. Certifier 1½ Certifying Phys | ician: To the best | of my knowledge, de | ath occurred at the | time, date and place | e, and due to the ca | ause(s) and manner as | s stated. | |
| e Ho 24 h e Fui letely | Medical | (Check only 2 Medical Examination) | ner: On the basis of and manner st | of examination and/or | investigation, in my | opinion, death occu | irred at the time, da | ate and place, and due | to the cause(s) | |
| 23b. Was decedent pregnant in the past 12 months? 1 2 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 3 Ectopic pregnancy 5 Other (specify) 1 Petal death 1 Petal | | | | | | se number | 29 | d. Date signed (Mont | h, Day, Year) | |
| J | | | | | | | 8/18/08 | 3 | | |
| / | | 30. Name and address of person who co | mpleted cause of o | leath (Item 23a) (Type | e, Print) | | | | 21204 | |
| | | Danielle Doberr | | 0. 6565 | N. Charl | es St, | Suite 2 | 09,Balti | 21204 more, MD | |
| Sta | to | 31. Date filed (Month, Day, Year) | | ar's Signature | | | | | | |

DHMH 17 Rev 1/2001

Registrar

AUG 2 1 2008

State of Maryland / Department of Health and Mental Hygiene [] [] 8

Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 27, 2008 04:50 A Arthur August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year Months Days If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 12 M 2 ☐ F **Funeral** Hours Director 220-09-8001 89 July 6, 1919 Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at Yes 2 ☐ No Maryland | Washington Hagerstown Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1041 Bramly U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Inforciant: if Item 27 is marked other then "naturel", or Itel any njury or other traumatic event, the Medical Exaction 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Henry Motz Florence Virginia Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Son John Motz 1041 Bramly Dr. Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 8/30/2008 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and physician at the burial-t Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical as attending i IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b Were autopsy findings available prior to completion of cause of death? ate has bage 2 s 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes director. 25. Was case referred to inclined 26. Place of De ill Check only one Other: 4 Linuxing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Pis 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending within 24 hours after death.

To the Funerel Director: A commetely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (CHECK UNIT) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) mpleted use of dea. (Item (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:20 A M 2008 21 August Stuart Warren Mount /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery 4982 Sentinel Drive #402 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1∭ M 2□ F Ohio 82 **Director** 579-14-0235 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination must be notified at 1 □Yes 2 ▼No Director MD Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20816 4982 Sentinel Drive #402 **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 1943–45 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturers Representative Thermal Wire 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Estelle Ruth Pearce Jay Albert Mount 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4982 Sentinel Drive #402 Bethesda, MD 20816 Sandra Lee Mount/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 08/22/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signatele of Funeral Service Licensee MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 pproximate Interval Between Onset and Death 1 month 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carcinoma of the Pancreas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transil Due to (or as a consequence of): Box 68760, attending physician for use as the buris certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) P.0. been signed by the a should be detached t □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 □Yes 2 □XVo this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D07147 August 21, 2008 30. Name and address of person who completed cause of Allen A. Nimetz, M.D. 5530 of deal Nitem 23a) (Type, Print) 0 Lisconsin Avenue Suite 730 Chevy Chase, MD 20815 Strar's Signature 32 31. Date filed (Month, Day, Year) State AUG 2 2 2008 Registrar

Certificate of Death

23d. Date of delivery Month Vear Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy perform 2∯No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

28604

3. Time of Death

9. Birthplace (State or Foreign

SOUTH CAROLINA

10d. Inside City Limits

20785

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

2:10 P M

Reg. No.

2008

USA

14. Race - American Indian, Black, White, etc.

BLACK

2. Date of Death

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 X ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

D16273

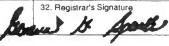
29d. Date signed (Month, Day, Year) 211 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REVATHY MURTHY M.D. 6130 LANDOVER ROAD CHEVERLY, MARYLAN 20785 31. Date filed (Month, Day, Year)

AUG 2 5 2008

1. Decedent's Name (First, Middle, Last)



Registrar DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Completed Be ٩ Certification:

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State

page

After

Director

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State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** August 13, 2008 2 :30 A M Shirley Jean /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner 405 South Parrot Drive Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 65 579-56-5739 Director Nov 29, 1942 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at 1 XYes 2 No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4235 Hayes Street, 20019 Funeral NE United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 No ρ Specify: American 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 College (1-4or 5+) years Elementary/Secondary (0-12) Managing Director Self Employed permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If item 27 is marked any injury or other the page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Dunn Mildred Barfield ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sheelena N. Nti - Daughter 405 South Parrot Drive Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 23, 2008 Landover, MD Stewart Funeral Rome, Inc. Harmony Mem. Park 22. Name and Address of Facility 21. Signature of Funeral-Service 4001 Benning Road, NE Washington, DC 20019 23a. Part1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) House dire 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ၉ this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours af er death e Funeral Director 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the the within To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 5 D59142 August 19, 2008 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) to

DHMH 17 Rev 1/2001

Registrar

Charles Boice,

1. Date filed (Month, Day, Year)

M.D.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

10301 Georgia Ave. #205 Silver Spring, MD 20902

| | | | 1 - For State Registrar | State of Maryla | | artment of H <i>rtificate of I</i> | | | ene 2 0 0 | 8 28606 | |
|--|---|----------------|--|--|-------------------------------|--|---|--|---|------------------------------------|--|
| | Bloods | | Decedent's Name (First, Middle, Las | t) | | | | 2. Date of Death | | 3. Time of Death | |
| | Physici: /Medic | | Saul Ruben | Pineda | | | | Month August | 12, 2008 | 11:00 a ^M | |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | | | | | 4c. County of Death | | |
| and the same | Funeral | • | Shady Grove Adven 5. Social Security Number 6. Se | | L s. last birthday) | Rockvi If Under 1 Year | . LLe If Under 24 Hrs. | 8. Date of Birth | Montgo | mery Birthplace (State or Foreign | |
| | Director | | | M M 2□F | 52 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, 1arch 30 | ,1956 E1 | Country) \ Salvador | |
| | and | | Usual Residence of Decedent 10a. State 10b. County | 10c. 0 | City, Town or Lo | cation | | | | 10d. Inside City Limits | |
| 5-UU36 72 hours after death with the Marvland | Maryl I-f sho | ģ | Maryland Montgo | merv | Wheato | n | | | | 1⊠Yes 2 No | |
| | h the | Director | 10e. Street and Number | mery | WIICaco | 10f. Zip Code | | 10 | g. Citizen of What | Country? | |
| | 23a c | | 8719 Bell Tower D | rive | | 2090 | 2 | | United S | tates | |
| | be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; | | Was Decedent of H If Yes, specify Cuba 1 ⊠Yes 2 ☐ No | ispanic Origin? (Spe an, Mexican, Puerto Specify: | | Black, W Specify: | | |
| 12-0036 | 2 hour | | 15. Decedent's Edu | ucation | 16a. Dece | dent's Usual Occup | ation | lvadoria 1 | n Ot 6b. Kind of Busine | her ss/Industry | |
| 7 | within 7; iene. than "n | Completed | (Specify only highest grad Elementary/Secondary (0-12) | de completed) College (1-4or 5+) | (Give | kind of work done of DO NOT use retired | during most of workii 1) | ng | | | |
| Z | e filed wii al Hygien other th vent, Ilv | | | 3 | | Salesman T | | | Insura | nce | |
| and | lid be fill fental F rked oti | Be | 17. Father's Name (First, Middle, Last) Saul R. | Pineda | | | 18. Mother's Name | | | | |
| \geq | 2 should be and Menta is marked a | 오 | 19a. Informant's Name/Relationship (7 | | 19b. Mailir | ng Address (Street | Lilian and Number or Rura | D . | Apari City or Town, State | | |
| Na Na | and 2: ealth a n 27 is ner trau | | Manuel A. Pineda | | | | cut Ave; | | • | | |
| e G | es 1 of H fiter | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | 20b | | sition (Name of natory or other plac | | | 0c. Location - City | | |
| Баппто | Parine Parine | | 4 Donation 5 Other (Specify | nemoval mom state | 1 Souls | Cemeterv | 8/20/ | 2008 | ermantow | n, MD | |
| סמ | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute | | | | | | | | |
| | | | 23a, Part 1. Enter the disease or comp | lications that caused the de | | | ille Pike | | | Approximate | |
| | Physician | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death | | | | | | | | |
| | /Medical | | disease or servition resulting in death) | a. Due to (or as a conse | equence of): | WEON | AINC | | | Onlow | |
| Examine | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury) b. ADULT PESPIQ ATOMY DISTRICTS Due to (or as a consequence of): CAUS STAGE DISTRICTS CAUSE OF TRACE DISTRICTS DISTR | | | | | | DO ONC | Unbour | |
| | ecuter and transi | Examiner | that initiated events c. | | | | | SE | | Unknown | |
| COIDS, F.O. BOX 00/00, v requires that the death certificate be ex | icate be ey physician s the burial | edical E | | d. DIABER | | MIELL | ITUS | | | Unknun | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 but outs after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | hysician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown | tal death 3 | ☐ Ectopic pregnanc ☐ Other (specify) | у | | 23d. Date of Month | delivery Day Year | |
| | quires that en signed b uld be deta | by P | | | | | | 23e. Did toba | id tobacco use contribute to the cause of death? □ Yes 2 2 No 3 □ Probably 4 □ Unknown | | |
| Jac I | The law recate has be page 2 sho | Completed | | | | | | 24a. Was an autopsy perform | prior | | |
| <u> </u> | ician certifi ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | Oth | 26. Place of Death | | | | |
| 5 | Phys ar this eral dii | : To | 1 Yes 2 No 27. Manner of Death | 1 Impatient 2 28a. Date of Injury | ☐ ER/Outpatier 28b. Time o | | 4 LI IVUISING Hol | me 5 Resider | nce 6 Other (5 | Specify) | |
| Attending Phy | nding ath. r: Afte e fune | atior | 1 Natural 5 Pending 2 Accident investigation | (Month, Day, Year) | Injury | Work | (? Yes 2 □ No | | vanjary occarrou | | |
| <u> </u> | r Atte ter dea irecto | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At building, etc. (Spe | home, farm, str cify) | eet, factory, office | 1 | 28f. Location (Str. City or Town, | | Rural Route Number, | |
| 2 | oital o urs af eral Di | | | | | | | | | | |
| | e Hosp 124 ho e Fune eletely f | Medical | 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) | | | | | | | | |
| • | To the within comp | Me | 29b. Signature and title of certifier | Somos, | KID | 29c. Licens | e number)62393 | 29 A | d. Date signed (M | onth, Day, Year) 2 2008 | |
| | | | 30. Name and address of person who c | | | * | 401; Rocky | | | | |
| | Sta | te | Petek Donmez, M.I 31. Date filed (Month, Day, Year) | ₽. Registrar's Sig | nature | TIKE, 1/2 | HUI; KOCKY | итте, М | 20032 | | |
| | Registr | | AUG 2 1 2008 | Eldin B | 1 1000 | (i) | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - State AMEND#4, perINF, 9/2/08, DPS, McCo Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 2008 5:25 A^M Lillian Rose Perry August 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 579al 14cu 8900 mber 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 578-20-5986 Director May 11, 87 1921 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD Silver Spring 28a-f Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or U.S.A. 15316 Pine Orchard Drive #2B 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No. Specify Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Artist Art marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Harry Witkin Lena Segal 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Perry - Husband 15316 Pine Orchard Drive #2B Silver Spring, MD 20906 Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 nent of h 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Lebanon Cemetery 8/20/2008 4 ☐ Donation 5 ☐ Other (Specify) Mt. Adelphi, Maryland 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction 45 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Multivessel Coronary Artery Disease 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> sign be Hypertrophic Cardiomyopathy 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page or Attending Physician: The perform Lower Gastrointestinal Bleeding 2**⊠**No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2∑XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation To the Hosping.

within 24 hours after death.

To the Funeral Director: A r death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 20

10

State Registrar

Reed Shnider, 31. Date filed (Month, Day, Year) AUG 2 1 2008



30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

MD

State of Maryland / Department of Health and Mental Hygiene Timothy James Poole 2008 28608 Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month August 19, 2008 Physician/ 2053 hrs **Medical Examiner** Timothy James Poole c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert Prince Frederick 495 Seagull Beach Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Country) **Funeral** Months Days ugust 8,1961 Director 1 X M 2 47 212-88-8621 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yes 2 X No Prince Frederick Calvert Maryland 23a or 28a-f show notified at once. permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10g, Citizen of What Country? Director 10f. Zip Code 20678 10e. Street and Number 495 Seagull Beach Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 Never Married 1 X Yes White 1 Yes 2 X No specify: Specify: 4 X Divorced If Yes, Give Year 3 Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Metal College (1-4 or 5+) Elementary/Secondary (0-12) Fabricators American Baltimore, MD 21215-0036 Welder 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon A. Burke James P. Poole Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) 2 495 Seagull Beach Rd., Prince Frederick, MD 20678 James P. Poole/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Adgust 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Leonardtown, MD Charles Memorial Gardens 25,2008 Donation 5 Other Specify 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Cor 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Medical Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and sician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, 23d. Date of delivery 23c, If yes, outcome of pregnancy IE EEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown a Unknown signed by the be detached fi Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Probably 4 Unknown 1 Yes 2 ✔ No 3 þ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' page 5 Yes 2 V No Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other, Hospital: Residence 6 V Other: Scene examiner? Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 ✔ Yes မှ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Subject shot Certification: Aug 19, 2008 2045 hrs ___ Natural 1 Yes 2 V No Pending within 24 hours after death. To the Funeral Director: completely filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 495 Seagull Beach Road, Prince Frederick, MD Could not be 3 🗸 Suicide determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certific August 20, 2008 O.C.M.E. 30. Name and address of person wh. Completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. egistrar's Signat 31. Date filed (Month, Day, Year) State Registrar OCME **ORIGINAL**

| | | 1 | _ State | State of Ma | | | rtment of H tificate of L | | | gienė Reg. No. | 2008 | 28609 | |
|----------------------------|--|-----------------|---|---------------------------------------|-------------------|-----------------------|---|---|------------------------------------|-------------------|----------------------------------|--|--|
| _ | | | 1. Decedent's Name (First, Middle, Last) | | | 001 | incate or E | | 2. Date of De | ath | | 3. Time of Death | |
| | Physicia | | Harold Pfist | er | | | | | August | Day 27 | 2008 | 5:55 A M | |
| | /Medic Examin | | te. Fecility Name (If not institution, give st | | | | 4b. City, Town, or | Location of Death | | | County of Death | | |
| | LXdiiiii | CI | Devlin Manor 1 | | lome | | Cumber] | | | | Allegany | | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age | (In yrs. last bir | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | th y, Year) | 9. Birthr | place (Stete or Foreign | |
| | Director | | 219-14-5174 | M 2□F 8 | 33 | Yrs. | | | July 1 | 8, 1 | 9 2 5 Mar | ry].and | |
| | and * | - | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | n or Lo | ation | | | | | 10d. Inside City Limits | |
| | Manyli f sho | ō | MD Allegany | | Cumber | lan | đ | | | | | 1 ☐ Yes 2 X No | |
| | the t | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citiz | en of What Cou | ntry? | |
| | death with the Maryland ms 23a or 28a-f show ringst be notified at | | 13912 Craddock Rd | SW | | | 21502 | 2 | | | .S.A. | | |
| | | Funeral | | 2. Was Decedent E Armed Forces? | er in U.S. | 13. V | Vas Decedent of Hi Yes, specify Cuba | ispanic Origin? (S n, Mexican, Puert | pecify Yes or No o Rican, etc.) |)- 1 | 4. Race - Ameri Black, White, | | |
| ٥ | after or Ite | F | 1 ☐ Never Married 2 ☑ Married | 1 Yes 2 □ N | 1942 | | ☐ Yes 2♥ No | Specify: | | | Specify: Wh: | | |
| 9500-6121 | hours after tural', or Ite | d by | 3 Widowed 4 Divorced | Year or Dates: | 1945 | Paras | ent's Usual Occup | ntion | | 16h Kir | VVII. | | |
| 7 | "nati | Completed | 15. Decedent's Educ (Specify only highest grade | ation completed) | 16a | (Give | kind of work done o | during most of wor | rking | 100.11 | | , | |
| 7 | withir ene. than | E C | Elementary/Secondary (0-12) | College (1-4or 5 | +) | Mas | onry | | | Co | ntracto | 2 | |
| 0 | be filed within 72 tal Hygiene. d other than "nai event, the Medic | | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Nar | ne (First, Middle | , Maiden | Sumame) | | |
| a | hould be filed withind Mental Hygiene. marked other than matic event, the M | To Be | George Pfister | | | | | Nannie | Elizabe | eth (| Cherry) | Pfister | |
| Maryland | should ind Men ind marke umatic | | 19a. Informant's Name/Relationship (Typ | | | | g Address (Street | | | | | | |
| | and 2 ealth a n 27 ls | | Norma Pfister | Spous | 7 122 | | 2 Craddo | | | | • | 1502 | |
| Ze | of He of He I Item r oth | | 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Re | moval from State | 20b. Place o | of Dispo ery, crer | sition (Name of natory or other plac | ce) | Date | | cation - City or T | | |
| Ĕ | Pages nent of ant: If It ury or o | | `4 □Donation 5 □Other (Specify) | inovarnom otato | Rest I | | Mausole | | | | Vale, M | | |
| Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic en | | 21. Signature of Funeral Service License | Ja Day | . Tu | 22 | Name and Addre | | | | | | |
| | | | 23a. Parti. Enter the disease, or complice shock, or heart failure. List only on | ations that caused | the death. Do | not ent | | | | | | Approximate Interval Between | |
| | 3. | | Immediate Cause (Final | e cause on/each lir | ne. | | | | | | | Onset and Death | |
| | Physician /Medical | | disease or condition resulting in death) | Due to (or as | a consequence | of): | in Pr | comerc | | | | 0 0001 | |
| | Examiner | | | | V | | | | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequence | of): | | | | | | | |
| | cuted nd ransi | Examiner | lital littlated events | | | | | | | | | | |
| Ö, | Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Ä | resulting in death) Last | Due to (or as | a consequence | of): | | | | | | | |
| 8760, | ate b hysic the b | dlcal | d | | | | | | | | | | |
| 9 × | that the death certific ed by the attending p detached for use as t | by Physician/Me | IF FEMALE: | 3c. If yes, outcome | of pregnancy | | | | | | 23d. Date of deli | verv | |
| Box | attendation | lan | in the past 12 months? | | 2 Fetal deat | | Ectopic pregnancy Other (specify) | 4 | | | Month | Day Year | |
| o. | the de y the ched | isic | 1 Yes 2 No 9 Unknown | 9□ Unknown | | | | | | | | | |
| ص | res that igned by | y Pł | Part II. Other significant conditions con | tributing to death b | ut not resulting | in the u | nderlying cause giv | en in Part I. | 23e. Did | tobacco u | use contribute to | the cause of death? | |
| <u>sp</u> | quires n sign | d be | Demini COP | D | | | | | 1 | Yes 2. | □No 3□Pro | obably 4 🗀 Unknown | |
| 00 | sw requir s been si s should I | Completed | | | | | | | 24a. Wa | s an | 24b. Were au | topsy findings available completion of cause of | |
| Re | The ta te ha | шо | | | | | | | per 1 ☐ Yes | formed? | death? | | |
| ta | sician: The certificate rector, pag | BeC | 25. Was case referred to medical examiner? | | | | | | ath (Check onl | one | | | |
| _ | Physician: The laviths certificate has al director, page 2 | ToE | 1 Yes 2 No | ospital: 1 🗌 Inpatio | | | | A- IAUI SILIY | - | | 6 □Other (Spec | cify) | |
| 0 | ng Pl fter tl inera | ü. | 27. Manner of Death 1. ■ Natural 5 ■ Pending | 28a. Date of Inju (Month, Da | iry 28b. | Time o | Wo | ryat rk?]Yes 2 □ No | 28d. Describe | now inju | ry occurred | | |
| Sio | tendi leath. tor: A the fu | cati | 2 Accident investigation 3 Suicide 6 Could not be | 29a Place of In | iun. At home | farm et | M 1 C | 1.62 5 140 | 28f. Location | (Street ar | nd Number or Ru | ural Route Number, | |
| Division of Vital Records, | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification; | 4 Homicide determined | building, e | ic. (Specify) | iaiii, si | eet, lactory, onlos | | | own, State | | | |
| _ | To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the complet | | 29a. Certifier 1 Certifying Phys | sician: To the best | of my knowledg | ge, dear | h occurred at the ti | me, date and plac | e, and due to th | e cause(s |) and manner as | stated. | |
| | 24 hos 24 hos Fur etely | edical | (Check only 2 Medical Examinations) | ner: On the basis of and manner st | of examination a | ind/or ir | ivestigation, in my | opinion, death occ | curred at the time | e, date an | d place, and due | to the cause(s) | |
| | within 2 To the I | Me | 29b. Signature and title of certifier | | | | 29c, Licen | se number | | | te signed (Monti | | |
| } | , , , , , | | > Sh | Cleri Is | -W | | D 6 | 0/756: | 5 | ac | eg. 2 F. | 1008 | |
| | | | 30. Name and address of person who co | mpleted cause of | death (Item 23a | | Print) | Lal | | | 5 , | _ | |
| | | 135 | A-JBUILTHO | | | 2+ | | L20 | LIC, M | D | 7/501 | | |
| | | ate | 31. Date filed (Month, Day, Year) | 32 Regist | rar's Signature | d | auth) | | | | | | |
| | Regist | rar | SEP 0 5 20 | UO FERRE | as the | 5 | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Gertrude Jane Rose 4:18 PM 19, /Medical 2008 August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Golden Living Center Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 06/10/1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🕏 F 85 Director 216-18-1640 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11703 Crocus Avenue 21502 USA Completed by Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Charles Knepper Elizabeth Margaret ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Rose / Husband 11703 Crocus Avenue, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cumberland Crematory: 08/23/2008 Cumberland MD 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician soble /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of that the death certificate be executed ed by the attending physician and detached for use as the bunal-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed?

1 Yes 250 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After or Attending 1-Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death filled in by the 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

31. Date filed (Month, Day, Year)

AUG 2 0 2008

D33280

625 Kent Avenue, Cumberland, MD

August 20, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Raines John Martin 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lions Center for Rehab & Ext. Care Cumberland 9. Birthplace (State or Foreign Country) West Virginia if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☑ M 2 ☐ F 215-20-6694 04/11/1915 Director 93 Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2 X No MD Allegany Cumberland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be n USA 21502 10906 Mason Road Funeral 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items; any Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. ☐ Yes 2 X No Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White Specify: ≥ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Tire and Rubber Machinist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thompson Raines Cena Charles Edward ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. Box 3, Spring Gap, MD Christine Robey / Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/20/2008 Cumberland, MD Hillcrest Mem. Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Sk notur of Funeral Service License 21502 404 Decatur Street, Cumberland, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death acostatic Immediate Cause (Final netastatic Physician Unknown disease or condition resulting in death) /Medical Due to (or as e consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending pl 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2[/] No 1 Inpatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manper of Death Certification: After 1 (Month, Day Year) Injury Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Table Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 121244 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Broadway Street, Frostburg, MD 21532 Jesus Tan, M.D., nde 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 8 2008 Registrar

DHMH 17 Rev 1/2001

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exercises.

Physician

/Medical

Examiner

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within 24 hours after death To the Funeral Director:

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| if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec | men | tig) |) | Jagys Years |
|--|--|--------------------------------|---|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown | al death 3 Ectopic | | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions | contributing to death but not res | sulting in the underlying | cause given in Part I. | | |
| 25. Was case referred to medical | | | 26. Place of De | eath (Check only one) | |
| examiner? 1 Yes 2 No | Hospital: Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing | Home 5 ☐ Residenc | e 6 ☐ Other (Specify) |
| 27_Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how | injury occurred |
| 3 Suicide 6 Could not be determined | | iome, farm, street, factorify) | ory, office | 28f. Location (Stree City or Town, S | et and Number or Rural Route Number, State) |
| | hysician: To the best of my kn miner: On the basis of examin and manner stated. | | | | se(s) and manner as stated. e and place, and due to the cause(s) |
| 29b. Signature and title of certifier | Au | v Mo | 29c. License number | | Date signed (Month, Day, Year) |

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State Registrar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SI DOTAU

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

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law requires that the death certificate be executed and attending physician signed by the certificate has After this within 24 hours after death To the Funeral Director: filled in by ö

Division or Vital Records, P.O. Box 68760,

Hospital

| that initiated events resulting in death) Last | C. Due to (or as a cons | equence of): | | | | |
|--|--|---|--|--|--|--|
| that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditi | 23c. If yes, outcome pf preg 1 □Live birth 2 □ Fr 4 □ Pregnant at time o | etal death 3 □Ectopic p | | | 23d. Date of deliv Month | rery Day Year |
| Part II. Other significant conditi | ons contributing to death but not r | esulting in the underlying of | cause given in Part I. | 23e. Did tobacco | | the cause of death? |
| | | | | 24a. Was an autopsy performed | prior to co death? | opsy findings available ompletion of cause of 2 □ No |
| 25. Was case referred to medical | il II | | 26. Place of De | eath Check onl one | | |
| examiner? 1 ☐ Yes 2 🔀 No | Hospital: 1 N Inpatient 2 | ☐ ER/Outpatient 3☐ D | OA Other: 4 Nursing | Home 5 ☐ Residence | 6 ☐Other (Speci | ify) |
| 27. Manner of Death 1 XNatural 5 Pendin 2 Accident investi | | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in | jury occurred | |
| 3 Suicide 6 Could 4 Homicide detern | | t home, farm, street, factor | y, office | 28f. Location (Street City or Town, St | and Number or Rui ate) | al Route Number, |
| 27. Manner of Death 1 X Natural 2 \ \text{ Accident} \ 5 \ \text{ Pendii investi} \] 3 \ \text{ Suicide} \ 4 \ \text{ Homicide} \ 6 \ \text{ Could detern} \] 29a. Certifier (Check only one) 29b. Signature and title of certifications. | ng Physician: To the best of my li Examiner: On the basis of exam and manner stated. | knowledge, death occurred ination and/or investigation | dat the time, date and pla n, in my opinion, death oc | ce, and due to the cause curred at the time, date | e(s) and manner as and place, and due | stated. to the cause(s) |
| 29b. Signature and title of certific | er | 29 | c. License number | 29d. I | Date signed (Month | , Day, Year) |
| 1 k. se | · Catha | I am | 0064 | 530 8 | 200 | 8 |
| 30. Name and address of person | who completed cause of death (I | tem 23a) (Type, Print) 10724 Little | Patuxent Pl | kwy, Ste 200 | O, Columb | ia, MD 2104 |

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who complete CANU

1. Date filed (Month, Day, Year) AUG 2 2 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death augeist **Physician** JOSEPH S. ROBINSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 15 9. Birthplace (State or Foreign **Funeral** Min. 1 ₹ M 2 □ F Months Days Hours MARYLAND 217-36-6762 75 1933 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10b. County Yes 2 □ No Director MD PRINCE GEORGE'S LANDOVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7712 BENDER ROAD 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No BLACK δ Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE GOVERNMENT 0 : If item 27 is marked other or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES H. ROBINSON ပ္ BARLEY NEAL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other tra. MARY E. ROBINSON/WIFE 7712 BENDER ROAD LANDOVER, MARYLAND 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 8/22/2008 4 □ Donation 5 □ Other (Specify) CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 01 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, To the Hospital or Australy within 24 hours after death.

To the Funeral Director: After this certificate has been signs a nameletely filled in by the funeral director, page 2 should be ģ Steno 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7108 Homes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas 31. Date filed (Month, Day, Year) AUG 2 5 2008 State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Rose Smiroldo August 17 03:10 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Heritage Harbour Health & Rehab. Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🔽 F Months Days Hours Rhode Island 117-09-7478 90 05/29/1918 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanthor must be redified at 1 ☐ Yes 2 📉 No Director Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3252 Breckenridge Way 21140 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Giovanina Sarcinella Pasquale Esposito 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr once. 3252 Breckenridge Way, Riva, Maryland 21140 Michele S. Strong/Daughter 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State y of Sorrows | 8/22/08 | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD | West River, MD West River, MD 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of Sorrows Fan a Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the complex of the c Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed throu's after death.
Function Director After this certificate has been signed by the attending physician and stely fliled in by the functed director, page 2 should be detached for use as the burial-transit netsy fliled in by the functed director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hou's after
To the Funer-I Dire 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 AUG 2 0 32. Registrar's Signatur, 31. Date filed (Month. 2008 Registrar

State of Maryland / Department of Health and Mental Hygien® () Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:40 a.M Victor Harvey Stotler | August 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Julia Manor Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) P. Birthplace (Star Country)
April 24,1914 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**⊠** M 2□ F 94 Yrs. 213-03-0950 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Maryland Washington Hagerstown 1 Tyes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11 South Walnut Street 21740 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ant: It item 27 is marked other than "natural; or the ury or othar traumatic event, the Mudical Examina ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) refrigeration mechanic food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William K. Stotler Mary H. Dowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd Stotler - brother 1851 Meridian Drive, Hagerstown, Maryland Place of Disposition (Name of cemetery, crematory or other place) August 28, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Cedar Lawn Memorial Hagerstown, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kelules 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obstructive Discas **Physician** chron = disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Remal DiSCRSC Chron. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Monknown Dementi 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 ☐ Yes 2 No 1 Tyes 2□ No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death, To the Funeral Diractor: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 006039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6H-3 ARIN MUN SHED 31. Date filed (Month, Day, Xear) 32. Segistrar's Signature State 2008 Registrar

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State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 9 2008

| | | | For | State o | of Maryland | / Depa | rtment of H | lealth and N | Mental Hygie | ene 200 | 8 28618 |
|----------|--|----------------|--|-------------------------------|----------------------------------|-----------------------------|--|--|---|---|--|
| | | | Registrar | | | Cer | | | 2. Date of Death | . No. | 3. Time of Death |
| | Physicia | an | 1. Decedent's Name (First, Middle, | , Last) | | | | | Month August 1 | Day Year | 4:25 p M |
| | /Medic | al | Nika Stajka 4a. Facility Name (If not institution) | give street and no | (mber) | | 4h City Town or | Location of Death | August 1 | 4c. County of De | |
| | Examin | er | Springbrook Adv | | inber) | | SIlver S | | | Montgomer | y |
| | Eugeral | | | 6. Sex | 7. Age (In yrs. last | t birthday) | if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y | | rthplace (State or Foreign Country) |
| | Funeral Director | | 386-58-6880 | 1 🛣 M 2 🗆 F | 82 | Yrs. | Months Days | Hours Min. | Dec. 25, | 1925 A | bania |
| - | | | Usual Residence of Decedent | | | | | | | | 10d. Inside City Limits |
| - | rylan show | _ | 10a. State 10b. County | | 10c. City, 1 | lown or Lo | cation | | | | 1 □ Yes 2X No |
| : | Ba-f s | Director | , | e George' | s Adelp | phi | 10/ 7: 0: 1: | | 100 | a. Citizen of What C | Country? |
| 12 | in 19 | ë | 10e. Street and Number | | | | 10f. Zip Code | | | ited Stat | |
| | s 23a | erai | 8312 26th Place | | cedent Ever in U.S. | 12 1 | 20783 | lispanic Origin? (Sp | | | nerican Indian, |
| 2 | or item | y Funerai | 11. Marital Status 1 Never Married 2 Marri | Armed F 1 Tes If Yes, G | orces? 2 ∑X No iive | | lf Yes, specify Cuba 1 □Yes 2 🕱 No | an, Mexican, Puerto Specify: | Rican, etc.) | Black, Wh | ite, etc. White |
| | 2 hours atural", ical Evo | ted by | 3 Widowed 4 Divorced | Year or | | 16a. Dece | dent's Usual Occup | pation during most of work | kina 16 | b. Kind of Busines | s/Industry |
| 17 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Evantinet in ust the natified at | Completed | (Specify only highes Elementary/Secondary (0-12) | 1 | (1-4or 5+) | _ | DO NOT use retired rator | during most of work d) | | Hote1 | |
| 2 | filed Hygi other ent, I | BeC | 17. Father's Name (First, Middle, | Last) | | | | 18. Mother's Nam | ne (First, Middle, Ma | aiden Surname) | |
| <u> </u> | ld be lental ked (| To B | Frank Stajka | | | | | Mary K | iri | | |
| 2 | shou and N s mar umat | - | 19a. Informant's Name/Relations | hip (Type. Print) | | 19b. Maili | ng Address (Street | and Number or Ru | ıral Route Number, | City or Town, State | , Zip Code) |
| | and 2 salth a | | Nora Stajka- S | pouse | | | | | phi, MD 2 | 0783 | 7. 0.4 |
| 5 | es 1 a of He fiter | | 20a. Method of Disposition 1 ☐ Burial 2 【XCremation | | 20b. Pla | ce of Dispo netery, crea | osition (Name of matory or other pla | ce) A110 | 25 2008 | Dc. Location - City | |
| | Page ment ant: II | | 4 □ Donation 5 □ Other (S | | For | | coln Crem | liatory | | Brentwood | 1, MD |
| חשו | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. | | 21. Signature of Fundral Service | Licensee | hal | | | | imple Tri e, ROckvi | | 20852 |
| | | | 23a. Part 1. Enter the disease, or | complications that | caused the death. | Do not en | ter the mode of dyi | ng, such as cardia | or respiratory arre | st, | Approximate Interval Between |
| | Physician | 0.3 | shock, or heart failure. List Immediate Cause (Final disease or condition | | | 1022222 | | | | | Onset and Death |
| | /Medical | | resulting in death) | a. Due t | iple Mye o (or as a conseque | ence of): | | | | | |
| | Examiner | | Sequentially list conditions | b | | | | | | | |
| | p ti | iner | Sequentially list conditions, if any, leading to immediate cause. Electronic library that initiated events | Due t | o (or as a conseque | ence of): | | | | | |
| | ecute and trans | Examiner | that initiated events resulting in death) Last | c | o (or as a conseque | ence of): | | | | | |
| 2/00, | icate be executed physician and s the burial-transit | a E | | | , | , | | | | | |
| 0 | ficate phys s the | edical | | d | | | | | | | |
| XOD | n certi inding use a | N/W | IF FEMALE: 23b. Was decedent pregnant | | outcome of pregnan | | ☐ Ectopic pregnan | 1014 | | 23d. Date of | |
| | e death the atte | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | egnant at time of de | | Other (specify) | | | Month | Day Y ear |
| Ţ. | hat the | Phy | Part II. Other significant conditi | ons contributing to | death but not result | ting in the | underlying cause gi | iven in Part I. | 23e. Did tob | acco use contribut | e to the cause of death? |
| ecords, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | ed by | | | | | | | 1 ☐ Ye | s 2 X No 3⊡ | Probably 4 Unknown |
| ဝ | law re as bec 2 sho | Completed | | | | | | | 24a. Was ar autops | y prior | autopsy findings available to completion of cause of |
| vitai K | The ate h | E O | | | | | | | perform 1 Tes 2 | ned? deatl No 1 □ | n? ∕es 2□No |
| <u> </u> | cian: ertific | Be (| 25. Was case referred to medica examiner? | 1.to emited. | | | 100 | har | ath (Check only one | | |
| 0 | hysio this c | ြို | 1 Yes 2 No | | ☐ Inpatient 2☐ E | | SIL 3 DOA | | Home 5 ☐ Reside | | Specify) |
| <u></u> | ling F After unera | <u></u> | 27. Manner of Death 1 XNatural 5 □ Pendi | ng (M | te of Injury onth, Day, Year) | 28b. Time Injury | Wo | ork? ⊒Yes 2. □No | 200. Describe 110 | w injury occurred | |
| <u>s</u> | ttend death stor: / the f | icat | 3 Suicide 6 Could | | ce of Injury - At hor | me, farm, s | | | 28f. Location (St | reet and Number o | r Rural Route Number, |
| UIVISION | lor A after Direct Jin by | Certification: | 4 ☐ Homicide determ | nined bu | ilding, etc. (Specify, |) | • | | City or Town | , State) | |
| | To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as | | (Check only 2 Medica | I Examiner: On th | the best of my know | vledge, dea ion and/or | ath occurred at the investigation, in my | time, date and place opinion, death occ | ce, and due to the courred at the time, d | ause(s) and manne ate and place, and | er as stated. due to the cause(s) |
| | o the | Medical | one) 29b. Signature and title of certific | | anner stated. | 1 | 29c. Licer | nse number | 2 | 9d. Date signed (M | onth, Day, Year) |
| | r s F ŏ | | 1 | D) | Spent | / | N D522 | 61 | | August 18 | , 2008 |
| | 4 | | 30. Name and address of person | who completed c | ause of death (Item | 23a) (Type | | | | | |
| | • | | 30. Name and address of person 1500 Forest G1 | en Drive | , Silver | Sprif | ig MD, ŽŨ | 772, | | | |
| | St | ate | 31. Date filed (Month, Day, Year | | Registral s Signal | ure | 0 AE 0 | | | | |
| | Regist | | ## H H H E T V # # " | ZIIIX LES | Charles S. | A Marke | 985LBM57 /5" //7 | | | | |

| 1 · · · · · | | State of State of Registrar | | artment of Health and rtificate of Death | Mental Hygien | 2000 20010 |
|--|-------------------|--|--|--|---|---|
| Physici /Medi | | 1. Decedent's Name (First, Middle, Last) Sidney SHULMAI | V | | 2. Date of Death Month August 18 | Oay 2008 7:33 A.M |
| Examir | | 4a. Facility Name (If not institution, give street and number Holy Cross Hospital 5. Social Security Number 6. Sex 7 | | 4b. City, Town, or Location of Deat Silver Spring If Under 1 Year If Under 24 Hrs | | c. County of Death Montgomery 9. Birthplace (State or Foreign |
| Funeral Director | | 5. Social Security Number 579 − 36 − 4008 6. Sex 1 | Age (In yrs. last birthday) 77 Yrs. | Months Days Hours Min. | (Month, Day, Yea | |
| ne Marylan 8a-f show ziilied at | ector | 10a. State 10b. County Montgomery | 10c. City, Town or Lo | ring | | 10d. Inside City Limits 1 □ Yes 2√ No |
| ath with the s 23a or 2 | Funeral Director | 8600 Sundale Drive | | 10f. Zip Code 20910 | | Citizen of What Country? |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be rediffied at once. | þ | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dat | es: Korean | Was Decedent of Hispanic Origin? (5 f Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 □ No Specify: dent's Usual Occupation | | 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry |
| d within 72 giene. er than "na , the Madic | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4) | (Give life. I Salesi | kind of work done during most of wo DO NOT use retired) Man/ Manager | rking Hec | ht Company |
| Ital ylallo | To Be (| 17. Father's Name (First, Middle, Last) Abraham Shulman | | 18. Mother's Na Lena | me (First, Middle, Maidle Ledgin | en Surname) |
| and 2 sho lealth and m 27 is m | | 19a Informant's Name/Relationship (Type Print) Dolores B. Shullman -wif | | Sunda le Dr., Sill | | |
| t. Pages 1 rtment of H rtant: If ite | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from St 4 ☐ Donation 5 ☐ Other (Specify) | | d Garden Aug | g. 20,20 <mark>08</mark> | Falls Church, VA ebrew Funeral tiome |
| permi Depa Impo | | 21. Signature of Funerial Service Licensee 23a. Part1. Enter the disease, or complications that car | 2 | 54 Carroll St., I | WW Washin | gton, DC 20012 |
| Physician /Medical Examiner spiritual and physician and ph | dical Examiner | shock, or heart failure. List only one cause on ear immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. | iopulmonary r as a consequence of): | Arrest er Hemorrhage | | Approximate Interval Between Onset and Death |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit | hysician/Medi | in the past 12 months? | ant at time of death 5 | □ Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year |
| w requires that been signed be should be deta | by P | Part II. Other significant conditions contributing to dea Chronic Kidney Disease | ath but not resulting in the u Stage V | nderlying cause given in Part I. | | to use contribute to the cause of death? 2 No 3 Probably 4 N Unknown |
| ian: The law rection trifficate has bee | Completed | | | | 24a. Was an autopsy performed 1 ∐Yes 2 ☑ | |
| yslciar yslciar nis certif director | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Xin | patient 2 ER/Outpatie | _ Other: _ | eath (Check only one) Home 5 Residence | 6 ☐ Other (Specify) |
| ending Ph sath. or: After th | Certification: To | 2 Accident investigation | f Injury 28b. Time o , <i>Day, Year)</i> Injury | f 28c. Injury at Work? M 1 □ Yes 2 □ No | 28d. Describe how in | njury occurred |
| vital or Att urs after de ral Direct | | 4 Homicide determined building | of Injury - At home, farm, str g, etc. <i>(Specify)</i> | | City or Town, St | |
| he Hosp in 24 hou he Fune pletely fi | Medical | (Check only 2 Medical Examiner: On the ba one) and mann | sis of examination and/or in | th occurred at the time, date and planestigation, in my opinion, death occurred. | | |
| (otl | Σ | 29b. Signature and little of certifler | Ém | 29c. License number D65069 | Auç | Date signed (Month, Day, Year) 3. 18, 2008 |
| | | | Forest Glen | Rd., Silver Spri | ng, MD | |
| Sta Regist | ate rar | | gistrar's Signature | ente | | |

1 - State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

28620

Physician /Medical Examiner

Funeral Director

28a-f show traumatic event, the Medical Exeminer must be notified at ō ,

of Health and Mental Hygiene. item 27 is marked other than of Health Department of Important: If it any Injury or o once.

Baltimore, Maryland 21215-0036

P.O. Box 68760. Records, Division of Vital

Physician /Medical Examiner signed by the a To the Hospital or Attending Physician: -within 24 hours after death.

To the Funeral Director; After this certifica ours after death.

neral Director; A completely

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day August 21, Smallwood Ladeane Burnette 2008 12:40 p^Mm. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 41495 Connelly Street, Apt. Leonardtown St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Davs Hours 217-42-1641 64 06/13/1944 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41495 Connelly Street, Apt. #26 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 🛱 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Local Government <u>Secretary</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Porter Williams Lillian L. Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Keith Smallwood/Son 22025 Oxford Court, Apt. C4, Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace Cem Helen, Maryland 08/29/2008 Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD Signature of Funeral S Brinsfield Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONACH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter thindrighing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ARTJOY DISTATE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MEUTIUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and of certifier DJ8098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. Gill, M.D. 24035 Three Notch Road, Hollywood, MD 31. Date filed (Month, Day, Year) AUG 26 egistrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:15 P M William Frederick Smith August 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 41367 Philip Lane Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours XXM 2□ F 92 Director 212-07-4215 May 15, 1916 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experiment and the recorded at 1 Yes 2 □ No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20650 United States 41367 Philip Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2XXNo If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2√TNo Specify: Specify: White 3₩idowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Telacommunications f Health and Mental Hygi Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fi Health and Mental H ဨ Frederick Jacob Smith Margaret Hecker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis Jacobs / Daughter 41367 Philip Lane Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If its any injury or o 1 ☐ Burial ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 08/28/2008 | Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensia M01206 Kyle S. Simons 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Merkel cell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transi and Due to (or as a consequence of): ng physician a Box 68760. Physician/Medical signed by the attending to be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 0 ☐Yes 2☐No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe After this certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \bigveeta Residence 6 \subseteq Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0055682 attendin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. W. I. K. M. D. 23130 Moakley St., Lean adtown, MD 20650 31. Date filed (Month, Day, Year)

AUG 2 9 2008 32. Registrar's Signature State

Registrar

| | | | State of Maryland / Department / Department / | artment of Health and M rtificate of Death | lental Hygi | iene g. No. 20 | 08 | 28622 | |
|-------------|---|------------------|--|--|---|----------------------------------|-------------------------|---|--|
| Ü | | | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death | h _ | | 3. Time of Death | |
| h | Physici: /Medic | | John A. Taylor, Jr. | | August | | OŎ8" | 9:58 P M | |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | | |
| H | Funeral | | | If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | | 9. Birtho | place (State or Foreign | |
| | Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-90-4713 30 Yrs. | Months Days Hours Min. | 10/19/1 | 977 | Mary | Tand | |
| | w w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo | ocation | | | 1 | 10d. Inside City Limits | |
| | Maryla f sho | p | Maryland Anne Arundel Davidson | ville | | | | 1 □Yes 2No | |
| | or 28a | irec | 10e. Street and Number | 10f. Zip Code | | 0g. Citizen of | | · | |
| | 23a c | ral | 882 Governor Bridge Road | 21035 | | United | | | |
| 9 | ould be filed within 72 hours after death with the Maryland Mental Hygiene. aarked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at | Funeral Director | 1 Nover Married 2 Married 1 Ves 2 No | Was Decedent of Hispanic Origin? (Spe If Yes, specity Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specity: | ecity Yes or No- Rican, etc.) | Bla | ck, White, | | |
| 003 | ural", | d by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | | - 1 | | y: Whi | | |
| 215-0036 | in 72 h | Completed | (Specify only highest grade completed) (Give | dent's Usual Occupation kind of work done during most of work DO NOT use retired) | ing | 16b. Kind of B | usiness/in | dustry | |
| 212 | d withing glene. | omo | Elementary/Secondary (0-12) College (1-4or 5+) Elect | rician | | Electr | ical | | |
| Maryland 21 | 4 2 2 4 | Be | 17. Father's Name (First, Middle, Last) John A. Taylor, Sr. | 18. Mother's Name Faith R. | | Maiden Surnai | me) | | |
| Ĭ | ages 1 and 2 should b nt of Health and Ment t: If item 27 is marked / or other traumatic e | မှ | | ng Address (Street and Number or Run | al Route Number, | ; City or Town | , State, Zij | o Code) | |
| Ž, | and 2 ealth a n 27 is ier trau | | , , , , , , , , , , , , , , , , , , , | Governor Bridge Roa | ad, Davi | dsonvi | 11e, | MD 21035 | |
| ore | of He | | 14A I Buriai 2 I I Cremation 3 I I Hemoval from State I | matory or other place) | | 20c. Location | - | | |
| Baltimore, | t. Pages rtment of rtant: If it | | 4 □ Donation 5 □ Other (Specify) Lakemont Mc | emorial Gardens 08/22 | | | | | |
| Ba | permit. Page Department Important: If any Injury o | | | 2. Name and Address of Facility Geo 273 Solomons Island | - | | | | |
| В | 123 | | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition | nexic Encept | 14/cpat | 7 | | Onset and Death | |
| | /Medical Examiner | | Due to (or as a consequence of): | , | / | / | | | |
| | EMASS. | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | |
| | ecutec and transi | Examiner | triat initiated events C. | | | | | | |
| 8760, | certificate be executed iding physician and ise as the burial-transit | | Due to (or as a consequence of): | | | | | | |
| 687 | ificate g phys as the | edical | d | | | | | | |
| XOX | leath certific attending p for use as | an/M | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Live birth 3 □ Fetal death | ⊒Ectopic pregnancy | | | ate of deliv | very Day Year | |
| O. B | 0 0 | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown in the past 12 months? 4 ☐ Pregnant at time of death 5 [9 ☐ Unknown | Other (specify) | | 14 | | Day Tour | |
| <u>.</u> | The law requires that the tite has been signed by the bage 2 should be detache | | Part II. Other significant conditions contributing to death but not resulting in the u | inderlying cause given in Part I. | 23e. Did tol | bacco use cor | ntribute to | the cause of death? | |
| rds, | w requires that s been signed E should be deta | ed by | | | 1 □ Ye | es 2□No | 3 □ Pro | bably 4 Unknown | |
| Record | law re as bee 2 sho | Completed | | | 24a. Was a | sy / | prior to co | opsy findings available ompletion of cause of | |
| | | Com | | | perfori 1□ Yes | med? 2 □ Mo | death? 1 ☐ Yes | 2 □ No | |
| Vital | sician certifi rector | Be | 25. Was case referred medical examiner? Hospital: Hospital: | 26. Place of Deat | | | | | |
| 0 | g Physer this eral di | 1: To | 1 ☐ Yes 2 ☐ Mo Propertient 2 ☐ ER/Outpatient 2 | AL Nursing Ho | ome 5 Reside | | , , | iry) | |
| ion | ending F ath. or: After he funera | ation | 1 atural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation | M 1 ☐ Yes 2 ☐ No | | | | | |
| Division or | or Att | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify) | reet, factory, office | 28f. Location (St City or Town | treet and Nun n, State) | ber or Ru | ral Route Number, | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification depends in by the funeral director, completely filled in by the funeral director. | edical C | 29a. Certifier (Check only one) 1 □ ertifying Physician: To the best of my knowledge, dea 2 □ Medical Examiner: On the basis of examination and/or in and manner stated. | th occurred at the time, date and place, nvestigation, in my opinion, death occu | and due to the c rred at the time, o | ause(s) and r | nanner as e, and due | stated. to the cause(s) | |
| ď | To the within 2 To the complet | Me | 29b. Signature and title of certifier | 29c. License number | 2 | 29d. Date sign | ed (Month | n,)Day, Year) | |
| 1 | NOW! | | 30. Name and address of person who completed cause of death (Item 23a) (Type | Print) (1/2/2 P) | A | 1000 | 2/11 | m | |
| | | ate | 31. Date filed (Month, Day, Year) AUG 2 0 2008 32. Fegistrar's Signature | Carlo |) //! | 10/10/10 | v / /J | 1 ' ' ' ' | |
| | Regist | rar | MUG N U. FOUL JORNAUS JO | | | | | | |

Amended #26, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08/20/08, Allegany Co., State of Maryland / Department of Health and Mental Hygiene 2008 per phy. 28623 Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pay August 18, 2008 Physician Year 10:50 A Olive Evelyn Tennant /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Assisted Living at Frostburg Village Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 X F 214-07-2462 91 April 04, 1917 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 100 Village Park Way 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r U.S.A 21532-Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) co-owner retail clothing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifton Walter Skidmore Priscilla Brode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellsworth Wayne Miller nephew 21550-19372 Garrett Hwv. Oakland Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 20, 2008 **Cumberland Crematory** Cumberland Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE LUNG Physician CHRONIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and sthe burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 2 No 9∏Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Mnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed; To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Assisted 1 Yes 20No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number His dem 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes 925 Bishop Walsh Sidha ARJIT CumberLAND Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 2 0 2008

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 28624 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Angus T 320 **Physician** Year AM /Medical ZU 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** Howard Co. General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month Day Year) May 21, 1937 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 👽 F Scotland Director 220-60-6122 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Westical Examination and the contribution of Maryland Prince George's Greenbelt ¥ Yes 2 □ No Director 10g. Citizen of What Country?
United States 10f. Zip Code 20770 10e. Street and Number 5-F Laurel Hill Road death \ by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Modical Examina 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 □Yes 2X No Specify. Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Accreditations Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen Brannen Scott George Tate Wood ပ 19a. Informant's Name/Relationship (Type. Print) Bryan R. Tiplady -son 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State Zip Code) 43919 Cheltenham Circle Ashburn, Va. 20147 Method of Disposition

14∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Greenbelt City Cemetery 8/21/200\$ Greenbelt, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 mintes **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and if be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed? 1 □ Yes 2 □ No certificate 1 □Yes 2 □No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check only within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Rint) 11065 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Physician 08 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HONARDTOWN ST. MARY'S HOSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours 578-18-0872 1□M 2**X**F Yrs. Director April 13/1921 Washington, DC Usual Residence of Decedent death with the Maryland State 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 No Funeral Director 28a-f 10e. Street and Numbe 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or in pinty or other traumetic event, the Medical Examiner must be reason. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: (1)HITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pau1 Hutchison Emory Lucy Mae Bowen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Faber/Daughter 29944 Burton Road, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 09/04/2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License P.O. Box 128, Charlotte Hall, MD 20622 M00817 Kelv 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perfo 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funerei I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed Month, Day Year) 29b. Signature and title of 30. Name and Indress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

David M. Federle

31. Date filed (Month, Day

egistrar's Signature

Hollywood, Maryland 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Charles Warren Todd August 21 2008 7:30 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F June 2, 1933 Director 220-28-4272 75 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ither traumatic event, the Medical Evantime must be notified at MD 1X Yes 2 No Dorchester Cambridge Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 414 East Appleby Avenue 21613 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No
If Yes, Give
Year or Dates: 1953 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) police officer city government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles M. Todd Ada Mills Pages 1 and 2 should or other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other tra Nancy Todd wife 414 East Appleby Ave., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 8/25/08 Hurlock, MD 22. Name and Address of Facility 21. Signature, Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) m 4 ocardia **Physician** /Medical Due to (or as a consequence of): Examiner COCONACU artery if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a cons uence of): the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 1 □Yes 2 □No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar Jas page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **X**No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Medical

V

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 20061877

29d. Date signed (Month, Day, Year)

SUJ Eyen St. Cambridge, MO ZIGIJ

08-06474 Jeffi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 28627

| ey Vance | 1- | For State Of Maryland / Department of the | eath | Reg. No. |
|--|-----------------------|--|--|---|
| Physicia | | edistrar Decedent's Name (First, Middle,Last) | 2. Date of I | Death 3. Time of Death 24, 2008 1120 hrs |
| ical Examir | ner | Jeffrey Lynn VANCE a. Facility Name (if not institution, give street and number) 4b. | City, Town, or Location of Death | 4c. County of Death |
| | 4 | a. Facility Name (il flot institution, give street and trains) | Hagerstown | Washington (State or |
| Funeral | Ę | Social Security Number 10. Sex | Manatha Dava Hours Min | f Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign |
| Director | 12 | 220-78-3259 1_M 2XF 47 Yrs. | Feb. | 25,1961 Country Maryland |
| ř. | | Jsual Residence of Decedent 10a State 10b, County Portrollow 10c. City, Town or Location | | 10d. Inside City Limits |
| J 10w any 6. | . H | Oa. State 10b. County Berkeley 10c. City, Town or Location Haryland Washington 10c. City, Town or Location Hagerstown | Falling Waters | 1 X Yes 2 No |
| arylane 8a-f sl at ong | Director | 10e. Street and Number 88 Yukon Drive | Of. Zip Code 25419 | 10g. Citizen of What Country? |
| the M a or 2 | ä | 1025 Pennsylvania Avenue | Decedent of Hispanic Origin? (Specify Yes | U.S.A. 14. Race - American Indian, Black, |
| h with ems 23 t be no | Funeral | 1 Married 2 Married Armed Forces? | , specify Cuban, Mexican, Puerto Rican, etc | |
| er deat , or it | 큔 | 3 Widowed 4 Divorced If Yes, Give Year 1 Y | 'es 2 X No specify: | Specify: |
| urs aft nural" | d b | Tor Dates: 160 Decedent's | Usual Occupation (Give kind of work done to of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| 5 72 ho an "na cal Ex | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | | sheet metal |
| Z1Z15-UU36 Nuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica | E O | 10 0 me ch. 17. Father's Name (First, Middle, Last) | 18.Mother's Name (First, Mic | |
| e filed tal Hyg ked or | Be C | Joseph Phillip Vance, Sr. | Shirl | ey Ann Whitmore |
| LIL tould b d Men d Men is mar tic eve | 입 | 19a. Informant's Name/Relationship (Type, Print) Shirley A. Vance — mother 130 R | Address (Street and Number or Rural Rout | own, Maryland 21740 |
| Baltimore, MID 21215-UU30 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlan Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once. | | 20b. Place of Disposition | ion (Name of cemetery. Date | 20c. Location - City or Town, State |
| Baltimore, permit. Pages I ar Department of He Important: If ite | | 1 X Burial 2 Cremation 3 Removal from State Cedar Lawr | ar place) August 2 n Memorial 2008 | Hagerstown, Maryland |
| it Pag urtment prtant | - 1 | | | nich Funeral Home |
| Department of the part of the | | SOM TITY / / / / / / / / / / / / / / / / / / / | East Wilson Blvd., | Hagerstown, Maryland 21 |
| Physiciar | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. | | Between Onset and Death |
| √Medica amine | | Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | ovascular Disease | |
| | | Sequentially list conditions, b | | |
| | ner | if any, leading to immediate Due to (or as a consequence or): | | |
| | Examin | (Disease or injury that initiated events resulting in death) Last | | |
| ecuted | | UNPENDED d. X AMENDED 10a-c,e,f per | inf g884 10-29-08 | vt |
| eath certificate be executed eath certificate be executed eather and eather transitions and transitions are the burial of transitions. | Physician/Medical | UNPENDED AMENDED TO TO THE POST OF THE POS | | 23d. Date of delivery |
| 3876 rtificat ing ph | an/N | 2 Fe past 12 months? 1 Live birth 2 Fe Pregnant at time of death 5 Onth | tal death 3 Ectopic pregnancy | Month Day Year |
| Box 6870 e death certifica the attending pl | Sici | 1 Yes 2 No 9 Unknown g Unknown | her (Specify) | |
| or the d | Ph | | underlying cause given in Part I. 23 | e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown |
| P.C ires that signed | 8 6 | | [24 | a Was an 24b. Were autopsy findings availa |
| w requ | shour plete | | | autopsy performed? death? Yes 2 No 1 Yes 2 No |
| Recort The la | Completed by | | 26.Place of Death (Check only on | Tes Z No |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that t rs after death. al Director: After this certificate has been signed by | ector & | examiner? Hospital: Inpatient 2 ER/Outpatien | t 3 DOA Other Nursing Home | e 5 Residence 6 Other: Scene |
| of Vision Physical Ph | Heral d | 1 Yes 2 No 28a. Date of Injury 28b. Time of | ,, | escribe how injury occurred |
| on on carding | the fur | 1 V Natural 5 Pending 2 Accident Investigation | 1 Yes 2 No | ocation (Street and Number or Rural Route Number, C |
| ivisior or Attend after death. | filled in by the fune | 2 Accident Investigation 3 Suicide 6 Could not be determined (Soecify) | | Town, State) |
| B Hospital | | | urred at the time, date and place, and due to | the cause(s) and manner as stated. |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and | completely | 29a. Certrifer (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation on the basis of examination and/or investigation of the basis of examination of the basis of examination and/or investigation of the basis of examination of the basis of examination and/or investigation of the basis of examination of the basis of examination of the basis of the basis of the basis of the basis of examination of the basis o | ation, in my opinion, death occurred at the tr | me, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) |
| To To | 103 | 29b. Signature and title of certifier | 29c. License number O.C.M.E. | August 25, 2008 |
| | | atile- Folloh n | O.O.IVI.L. | |
| | | the state of the s | | |
| 4-11 | | 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner | 111 Penn Street, Baltimore, MI | D 21201 |
| HIO | Sta | Patricia Aronica-Pollak MD. Assistant Medical Examiner | 111 Penn Street, Baltimore, MI | D 21201 |

| | | | State of Maryland / De | partment of Health and N Certificate of Death | lental Hygier/ Reg. ۱ | ne 2008 | 28628 |
|-------------|--|-------------------|--|---|---|--|---|
| ŀ | Physici | | 1. Decedent's Name (First, Middle, Last) Sofia J. Varveris | | 2. Date of Death Aug. 16, | 2008 Year | 3. Time of Death 11:30a м |
| ¥. | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) 8201 16th Street #406 | 4b. City, Town, or Location of Death Silver Sprine | | 4c. County of Death Montgome | ery |
| | Funeral Director | | 5. Social Security Number 6. Sex $1 \square M$ $2 \cancel{X}^F$ 7. Age (In yrs. last birthe 92 Yr. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Yea 4/10/19 | 9. Birthpla Countr 916 Gr | ce (State or Foreign y) eece |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any futury or other traumatic event, the Medical Examiner must be notified at <u>once.</u> | Funeral Director | Usual Residence of Decedent 10a. State Montgomery 10c. City, Town of Silve 10b. Street and Number 8201 16th Street #406 | r Location r Spring 10f. Zip Code 20910 | 10g. (| Citizen of What Countr | d. Inside City Limits 1 □ Yes 2 🖾 No |
| 0500-0 | 72 hours after de natural", or Items lical Examiner m | by | 1 □ Never Married 2 🔀 Married 1 □ Yes 2 🛱 No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2♥ No Specify: accedent's Usual Occupation | 16b. | 14. Race - America Black, White, et Specify: W Kind of Business/Indu | nite |
| 21717 | ed within 7 giene. er than "n the Medi | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | ive kind of work done during most of work e. DO NOT use retired) Homemaker | king | Own Home | |
| yland | ould be file Mental Hy arked oth | To Be (| 17. Father's Name (First, Middle, Last) Efstratios Tsintolas | Fotin | e (First, Middle, Maid ni Tsakar | estos | |
| , Mar | and 2 sh ealth and n 27 Is m | | John G. Varveris/Husband 82 | lailing Address (Street and Number or Ru. 01 16th Street # | 406 Silv | er Sprin | g,Md20910 |
| Dallinore | Pages 1 ment of H ant: If Itel lury or oth | | | | /2008 S | .Location - City or Tow ilver Spr | ing,Md |
| ם D | permit Depart Import any In | | 21. Signature of Puneral Service Ricepsed | PHTCTFAGSRINALDI 9241 Columbia Bl | .vd.Silve | SERVICE er Spring | <u>,Md20910</u> |
| 0,007 | Physician buyascian and physician street percentage with purial-transit | I Examiner | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Chronic Kidn Due to (or as a consequence of) Due to (or as a consequence of) | ey Disease | or respiratory arrest, | | Approximate Interval Between Onset and Death |
| .O. DOX 007 | The law requires that the death certificate tte has been signed by the attending physionage 2 should be detached for use as the | Physician/Medical | d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of deliver | ry Day Year |
| cords, r | equires the | by | Part II. Other significant conditions contributing to death but not resulting in the Hypertension | ne underlying cause given in Part I. | | co use contribute to the | |
| vital nec | (0 - | Completed | OF Western de madient | | 24a. Was an autopsy performed 1 Yes 2 🔀 | prior to con death? | osy findings available appletion of cause of 2 No |
| | ding Physician: After this certification funeral director, | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp | Other | th (Check only one) | e 6 □Other (Specify | rl |
| 5 | ig Phy ter thi | | 27. Manner of Death 28a. Date of Injury 28b. Tir | ne of 28c. Injury at | 28d. Describe how in | | / |
| NISIO | r Attending ter death. Irector: After I by the funer | Certification: | 1 ☑ Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined building, etc. (Specify) | M 1 ☐ Yes 2 ☐ No | 28f. Location (Street City or Town, St | t and Number or Rural tate) | Route Number, |
| ב | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi | | 29a. Certifier 1 Certifying Physician. To the best of my knowledge, (Check only 2 Medical Examiner: In the basis of examination and/ | death occurred at the time, date and place or investigation, in my opinion, death occu | e, and due to the caus | e(s) and manner as stand place, and due to | ated. the cause(s) |
| • | To the within 2 to the complex | Medical | 29b. Signature and title of partifier. | 29c. License number D26437 | 29d. | Date signed (Month, I August 18 | Day, Year) |
| | 3 | | 30. Name and address of person who completed cause of death (Item 23a) (To Steven Burka MD 5530 Wiscon) | pe, Print) sin Ave. #914 Ch | evv Chas | e.Md 2081 | 1.5 |
| I. | Sta | ate | 31. Date filed (Month, Day, Year) | | | | |

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 26, 2008 2008 2030 рм **Physician** Ernest Pershing Volkart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Harford Havre de Grace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) 9/24/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Mary land 1X M 2□ F 216-16-5385 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shot Injury or other traumatic event, the Medical Examiner must be notified at Aberdeen Harford MD 1 TXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21001 602 W. Bel Air Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any Injury or other traumatic event the Insulation of the Insulation of the Insulation of Insulation In Elementary/Secondary (0-12) 12 College (1-4or 5+) Banking Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Ripken Ernest Volkart ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen, MD 21001 Mary Ellen Volkart (Spouse) 602 W. Bel Air Ave. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/30/08 Aberdeen, Maryland Baker Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cance Physician /Medical Due to (or as an insequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063220 BEORGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2008 Mar garet 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner University of 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 87 Pennsylvania Director 157-01-3076 15,1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I've Medical Examination and Demotified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ▼ No Director MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 94 Stauffer Road 21146 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No <u>ک</u> Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Cargen Edward Erickson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Wilson Cummings/ Daughter 2005 Braddock Court Alexandria, VA 22304 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Oct. 1, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral H
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Juneral Service Licensee 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) **Physician** traceres. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3

Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performe 2 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Cutpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🖅 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the within 2

State Registrar

31. Date filed (Month, Day, AUG 2 0 2008

29b. Signature and title of coefficer

Registrar's Signature

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

8-06278 Diana

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

| Diana Ward | | | ate of Mar | yland / [| Departr Certifi | ment of icate of | Health a Death | and Men | tai Hygie | Reg. 1 | No. | 20 | 08 | 286 |
|--|----------------|--|---------------------------------------|---------------------------------|-----------------------------|----------------------------|------------------------------------|--------------------------|----------------|--------------------|--|--------------|----------------------|------------------------------------|
| | Red | or State ijstrar Decedent's Name (First, Midd | le.Last) | | OGIUII | | | | 2. D | ate of Death | | | 3. Time of | |
| Physician Me <i>dic</i> al Examine | , | Diana | Ward | | | | | | Ai | onth Daugust 16, 2 | 008 | | 1144 | nrs |
| Wedaraj Examine | 4a | . Facility Name (if not institution | | id number) | | 4 | b. City, Town | | of Death | | 4c. County | Anne's | | |
| | | Roman Coke Road @ |) Long Creel | < Drive | | | Stevens | | 0.000 | Date of Birth (| Birth (MM/DD/YYYY) 9. Birthplace (State or | | | |
| Funeral | 5. | Social Security Number | 6. Sex | 1 | (In yrs. last | birthday) | If Under 1 | Year If Und Days Hour | | 11/14/1 | | 1 Foreign | 1 | ryland |
| Director | 2 | 15-58-9861 | 1 M 2 X | (F | 56 | Yrs. | | , | | 11/14/1 | 931 | | | - J - Carlot |
| | U | sual Residence of Decedent | | | 0 0 T | as Lagati | - | | | | | $ \top$ | 10d. Insid | e City Limits |
| any | 10 | a. State 10b. County | | | Arno | wn or Locati | on | | | | | 1 | 1 Ye | s 2 X No |
| show | اة | | Arundel | | ALIC | | 10f. Zip Co | de | | 10g | . Citizen of \ | What Cour | ntry? | |
| daryla 28a-f | Director | De. Street and Number | لم. | | | | | 012 | | | USA | | | |
| | | 423 River Roa | | | | 140 W | n Depodent | of Hispanic O | rigin? (Speci | fy Yes or No- | 14. Ra | ice - Ameri | can Indiar | , Black, |
| ms 2. | <u>ہ</u> ا | Marital Status Never Married 2 X | 1 4 | s Decedent E ned Forces? | | If Y | es, specify C | uban, Mexica | n, Puerto Ric | an, etc.) | W | hite, etc. | | |
| death or ite | 5 | | 1 If Yes, Gi | Yes 2 | No | 1 | Yes 2 X | No specif | y: | | Specif | <i>)</i> . | ite _ | |
| ral", | <u> </u> | Widowed 4 5. Decedent's Education (Sp. | | | pleted) | 16a Decede | nt's Hsual Oc | cupation (Giv | e kind of work | | 16b. Kind of | | | |
| hours 'natu Exan | eted | Elementary/Secondary (0-1: | | ege (1-4 or 5 | | during n | nost of working | g life. DO NO | I use retired | ' | Dynas | plin; | t | |
| 36 in 72 han ' | be | 12 | " | | l | Admin | istrat | | | | | | | |
| 21215-0036 Auld be filed within 7 Mental Hygiene. marked other than | Comple | 7. Father's Name (First, Midd | le, Last) | | | | | | | irst, Middle, M | aiden Surna | me) | | |
| e file tal Hy ked o | <u>e</u> | Norman Mullin | nix | | | | | На | zel Go | rdon | or City or | Fown Stat | e. Zin Cod | ie) |
| 212 Men Mari | <u>.</u> 2 | 19a. Informant's Name/Relation | | | | | | | | al Route Numi | | TOWN, OLGA | v, =.p | |
| MD d 2 sho lth and n 27 is | | Claude L. Ward | 1/ husba | and | - Looi B | | River | | | oate | 20c. Locati | on - City o | Town, S | ate |
| Fe, Fand I and Healt I item | | 20a. Method of Disposition | tion 3 Ren | noval from St | ate c | rematory or o | other place) | | Aug. | | Dal | timor | o M | n |
| nor Pages ent of nrt: 11 | - | _ / 7= | Specify / | 1 | Me | | remato | | 200 | | | | | |
| Baltimore, permit. Pages 1 ar Department of Hee Important: If itel | • | 21. Signature of Funeral Serv | ice Licensee | 7 | |) B | Name and A | ddress of Fac | ns, P. | A. Seve | erna P | ark I | Funer MD 2 | al Home |
| in T De E | - 1 | 23a. Party. Ehrer the disease | 1011 | 1)00 | OM | 49 | 95 GOV | . Ritc | NIE HW | y Seve | est, shock, o | r heart | Appro | ximate Interva |
| Physician | | 23a. Part I. Enter the disease faiture. List only one car | , or complication use on each line | s that caused | the death. | Do not ente | the mode of | dynig odo | | , | | | Betw | een Onset and Death |
| Viedical aminer | | Immediate Cause (Final dise | _{ase} & Multip | ole Injuries | | | | | | | | | + | |
| anniei | | or condition resulting in deat | 1) Due to | (or as a cons | sequence o | 1): | | | | | | | | |
| | _ | Sequentially list conditions, if any, leading to immediate | D. Due to | (or as a cons | sequence o | f): | | | | | | | - | |
| | Examine | cause. Enter Underlying Ca (Disease or injury that initiate | use c. | | | | | | | | | | | |
| T is | xan | events resulting in death) La | ast Due to | (or as a cons | sequence o | 1): | | | | | | | | |
| iO, e be executed sysician and burial - transit | alE | | d | ENDED | | | | | | | | | | |
|), be ex sician | edical | UNPENDED | | c. If yes, outco | ome of pred | nancy | | | | | 23d. D | ate of deliv | /ery | |
| Sox 6876C leath certificate e attending phys for use as the b | an/M | IF FEMALE: 23b. Was decedent pregnant | in the | Live birth | one or pres | 2 | Fetal death | 3E | topic pregna | ncy | Mo | nth | Day | Year |
| K 68 s certi endin use a | sicial | past 12 months? | 4 | Pregnant | at time of d | eath 5 | Other (Spec | cify) | | | ŀ | | | |
| Box e death c the atten | Phys | 1 Yes 2 No 9 | | Unknown | -15 5-15 | ting in t | ne underlying | cause given | in Part I. | 23e. Did | tobacco use | : contribute | to the ca | use of death? |
| s, P.O. B ires that the de signed by the d be detached i | by P | Part II. Other significant co | inditions contr | ributing to de | ath but not | resulting in a | no dilabily in a | | | 1 Ye | s 2 🗸 N | o 3 F | ^o robably | 4 Unknow |
| , P irres t sign d be c | B | | | | | | | | | 24a. Was | | 24b. Were | e autopsy | findings availa tion of cause o |
| ords, w requir s been s should I | Completed | | | | | | | | | | ormed? | death | h? | 2 No |
| ecc he lav ate ha | E E | | | | | | | | | 1 122 | 2 No | | Yes | 2 110 |
| tal Rec cian: The l certificate l | Ö | 25. Was case referred to in | | | | | | Oth | Death (Check | ng Home 5 | Residenc | e 6 🗸 0 | ther: Scer | ne |
| of Vital Records, ng Physician: The law require After this certificate has been s' neral director, page 2 should the | 0 | examiner? | Hospit | П | atient 2 | ER/Outpa | | 28c. Injury at | | 28d. Describ | | | | |
| of of ng Ph | 1 2 | 27. Manner of Death | | 28a. Date of l FOUND: | Injury ay,Year) | 28b. Time | | | 2 V No | Driver auto | auto co | llision | | |
| On tendii eath | <u>i</u> | 1 Natural 5 2 ✓ Accident | Pending Investigation | Aug 16 20 | ากล | 1135 hr | s | | | 28f. Location | (Street and | Number | or Rural Ro | oute Number, (|
| Division tal or Attending Sign Atten | ifi cy | 3 Suicide 6 | Could not be | | | | street, factor | y, office build | ing, c.o. | | | | | e , Stevensvi |
| Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death After this certificate has been signed by the attending phys | Certification: | 4 Homicide | determined | | | ad / High | | e time date | and place an | d due to the co | use(s) and | manner as | s stated. | |
| Hosp 24 hc Fune | in je | | ing Physician: | To the best of the basis of the | of my knowle examination | edge, death on and/or inve | occurred at the stigation, in r | ny opinion, de | ath occurred | at the time, da | te and place | e, and due | to the cau | ise(s) |
| To the vithin | Medical | one) 2 Medica | anc | manner stat | ted. | | | oc. License n | | | 29d. Da | ate signed | (Month, E | Day, Year) |
| | 2 | 29b. Signature and title of | | mo | | | | O.C.M. | | | Augu | ıst 17, 2 | 800 | |
| | | his! | - 0 | | | 00-1 | | | | | | | | |
| 34 | | 30. Name and address of | person who com ssistant Medi | pleted cause | of death (It iner 1 | em 23a) 11 Penn 9 | Street, Bal | timore, MI | 21201 | | | | | |
| 10 | D. | | | | istrar's Sigr | | | | | | | | | |
| Per | Stat | e 31. Date filed (Month, Day | 2 0 2008 | | 1000 0 | K | Court. | , | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28632 For State RegistrarAMEND#20a,b,c perFH,8-21-08,BWI,McOGertificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug. 15, **Physician** 2008 WISER 11:24 AM VIVIAN D. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Director 5**77-**26-6**71**3 93 June 17, 1915 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be motified at 1 X Yes 2 ☐ No Director Maryland | Prince George's College Park 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 9522 50th. Place 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 **X**No Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 호 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Agricultural Historian Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental Hv Be Floyd Wiser Alice Ε. Hooke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3210 Wake Dr. Kensington, Md. 20895 C. Lawrence Wiser / Brother 20b. Place of Disposition (Name of Met Proposition (Name of Met Proposi Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Ale**z**andria, Virginia Adelphi, Maryland 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Savice Lice Donald V. Borgwardt Funeral Home, PA nen 74400 Powder Mill Rd. Beltsville, Md. 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroscleratio **Physician** Cardinoscular disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an cate has by page 2 s autopsy certificate 2 No 2 No 1 X Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Certification: To this funeral Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 2 Accident in 24 hours are:
the Funeral Director: Afternetely filled in by the funeral properties of the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

within 7

State Registrar

31. Date filed (Month, Day, Year) AUG 21 2008

29b. Signature and title of certifier



MD



29c. License number

29d. Date signed (Month, Day, Year)

16, 2008

the

State of Maryland / Department of Health and Mental Hygiene Reg. No.2008 28633 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08 0935 08 31 Watson Frank /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany WMHS Braddock Campus Cumberland 8. Date of Birth (Month, Day, Year) Jan 10, 1948 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) **Funeral 1**□ M 2□ F Months Days Hours "MD 60 Director 219-44-0759 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Inc Medical Examiner maist be notified at Cumberland Y ☐ Yes 2 ☐ No Allegany MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21502 437 South Street Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married Ž☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify: white ģ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. important: if flem 27 is marked other the any Injury or other traumatic event, Inc. once. drvwall 1:2 laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katheleen Green Watson Frank Lee Watson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 a Vale MD 21502 19a. Informant's Name/Relationship (Type. Print) 16 Glenview Terrace daughter Carol Femi 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/4/2008 MD Cumberland St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeful Service Lig 108 Virginia Avenue: Cumberland, MD 21502 e, vr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. a r . Enter the disea e sh r k, or heart failur . l Immediate Cause (Find disease or condition resulting in death) **Physician**) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transl Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached by 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 DING To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier D50844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI) 912 SETON PIZIVE CUMIZETZLAND, MD ZISUZ JOSE WIRIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 2008 Certificate of Death Month (1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 0535 M **Physician** 6120 6846 2008 /Medical 4a. Facility Name (If pot institution, give street and number) to. City, Town, or Location of Death 4c. County of Death Examiner Olnes montjonery 04D Axomeo Gen If Under 1 Year | If Under 24 Hrs. 9 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 578-16-3513 89 Georgia Director May 21, 1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15101 Interlachen Drive, # 422 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White Completed by 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Steinman Ida Rubin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula H. Zuckerman - Daughter 6603 Glenbrook Road, Chevy Chase, Maryland 20815 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gdns: 8/20/2008 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ature of Juneral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. water 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DILLO 707 /Medical Due to ras a consequence 1): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events MODME To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit on property. resulting in death) Last Due to (or as a consequence Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No ate of delivery 3 Ectopic pregr Month Day 5 Other (specify) Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1⊠'Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Division 5 ☐ Pending investigation 1 Natural Aug 4 2006 / 400 M 1E 28e. Flace of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2. Accident Number or Rural Route Number, 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street of d City or Town, State) determined 4 Homicide Nome Intellaken De #422 Silves Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD almost medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

29b. Signat

31. Date filed (Month, Day, Year)

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2008

DHMH 17 Rev 1/2001

Registrar

065292

2150 Pennsylvania Avenue, N.W. Washington, D.C.

29d. Date signed (Month, Day, Year)

20037

and manner stated

address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

VILLANLIEM, MY

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Lorraine Susanne YOUNKIN 9:16 a.M 21, 2008 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown 11 W. Baltimore Street Apt. 115 Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 217-82-5634 Sept. 27,1963 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show 11 Yes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examinar must be notified Director Maryland Washington Hagerstown 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 11 W. Baltimore Street Apt. 115 21740 U.S.A. Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, Its Mas Elementary/Secondary (0-12) College (1-4or 5+) Her own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be El don Robinson Nancy Beall 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Janes - Mother 11 W. Baltimore Street #1117, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown Crematory August 23, Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service License 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OPD disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? Yes 2 No The certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of performing completed cause of death (Item 23a) (Type, Print) 1-H0 trar's Signature 31. Date filed (Month, Day, State Registrar

Patricia Magealene Archer

| tricia Mageale | | i- For State | Stat | e of Maryla | and / Depa <i>Cer</i> | artment of tificate of | | and Me | ental Hy | giene | Reg. No. | 2 | 008 | 2863 |
|---|---------------|---|------------------|--------------------------------|--------------------------------|---------------------------|---------------------------------|-------------------------------|--------------------------------|------------------------------|---------------------|----------------------|--|---------------------------------------|
| Physicia | | Registrar 1. Decedent's Name (First, | Middle,L | ast) | | | | | | 2. Date of D Month | Day | Year | | e of Death 35 hrs |
| edical Exami | ner | PATRICIA | _ | IAGDALEN | | HER | | | a of Dooth | Septem | | 008 County of | | 35 1118 |
| • | | 4a. Facility Name (if not ins 3900 N. Charles | | | umber) | | 4b. City, Towr Baltimor | | on of Death | | | N | I/A | |
| Funeral | | 5. Social Security Number | 6. | Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 | Year If Ur Days Ho | nder 24Hrs. | - | | | Birthplace Foreign | |
| Director | | 218-52-4324 | 1 | M 2X F | 58 | Yrs | | Days | urs Iviiri | Oct. | 5, 1 | .949 | Country) | Maryland |
| any | | Usual Residence of Deced 10a. State 10b. Co | | | 10c. City, | , Town or Locat | ion | | | | | | | nside City Limits |
| ith the Maryland 23a or 28a-f show any notified at once. | 5 | Maryland | N/A | | Ва | ltimore | 9 | | | | | | | Yes 2 No |
| death with the Maryland or items 23a or 28a-f she must be notified at once | Director | 10e. Street and Number | | | | - | 10f. Zip Co | de | | | 10g. Citi | zen of Wh | at Country? | |
| h the | ₫ | 3900 N. Cha | arle | | | | | 21218 | = | 15 14 | | U.S. | A | dian Black |
| th wit | Funeral | 11. Marital Status 1 X Never Married 2 | Marri | A man and f | cedent Ever in U orces? | I.S. 13. Wa | as Decedent of es, specify C | of Hispanic (Juban, Mexic | Origin? (Sp. can, Puerto l | ecity Yes or Rican, etc.) | No- | White | | dian, black, |
| er dea | | 3 Widowed 4 | | 1 Yes | 2X No | 1 | Yes 2 X | No spec | cifv: | | | Specify: | White | |
| 5-0036 led within 72 hours after the "natural", other than "natural", the Medical Examiner | ğ | 15. Decedent's Education | | or Dates: | | 16a. Deceder | nt's Usual Occ | cupation (Gi | ive kind of w | ork done | 16b. I | | siness/Industr | у |
| 72 hou "mat | Completed | Elementary/Secondary | | | (1-4 or 5+) | during m | nost of working | g life. DO N | OT use retir | red) | | | | |
| 036 ithin 7; ne. r than ledical | ם | | | 4 yea | rs | V: | ice Pr | | | | | | ancial | |
| 215-0036 be filed within 72 hours after ntal Hygiene. rked other than "natural", on, the Medical Examiner. | | 17. Father's Name (First, I | vliddle, L | | | | | | ther's Name | , | | |) | |
| 2121 ald be fill Mental F marked c event, | Be | John . 19a. Informant's Name/Re | | Archer | | 4.0h Adeilin | a Address / | Ma | rgaret | Mary | Hous | ston | n, State, Zip C | 'ode) |
| Shou | 5 | Raleigh Moss | | | rother) | | | | | | | | yland | |
| 조 2 등 등 등 등 | | 20a. Method of Disposition | | (1) | | Place of Dispo | sition (Name | | | Date | 20c. | Location - | City or Town. | State |
| S 1 S 1 FF | | 1 Burial 2 X Cre | | | from State | crematory or o | | | _ | <i>l.</i> 00 | Do- | 1 + 1 | wa Ma | wrland |
| 트 집 한 분 님 | | 4 Donation 5 Of 21. Signature of Funeral S | ther Spec | cify: | Gre | een Mou | | | | -4-0 <u>8</u> | | | re, <u>M</u> a | гутапо |
| Balti permit. Departin Importi | y 10 | Leone L | Co | 1.4.0.4.0. | 0 | M | Name and Ad itchel 6500 Y | 1-Wie | defelo | l Fune | ral I | Home, | Inc. | 21212 |
| Physician | - | 23a. Part I. Enter the disea | ase, or co | omplications that | caused the death | h. Do not enter | the mode of d | lying, such a | as cardiac o | r respiratory | arrest, sh | ock, or he | art Ap | proximate Interval |
| Medical | 0 0 | failure. List only one Immediate Cause (Final d | | | sive Cardiova | scular Dise | ase | | | | | | | Death |
| xaminer | | or condition resulting in d | | Due to (or as | a consequence | of): | | | | | | | | |
| | <u>_</u> | Sequentially list condition | | b. | a consequence | of): | | _ | | _ | _ | | _ | · · · · · · · · · · · · · · · · · · · |
| | Examiner | if any, leading to immedia cause. Enter or denying (Disease or injury that init | Cause | C. | a consequence | 017. | | | | | | | 34 | |
| W D E | xan | events resulting in death) | | Due to (or as | a consequence | of): | | | | | | | - | |
| be executed ician and urial - transit | | | | d | <u>.</u> | | | | | | | | | |
| rici be | edical | UNPENDED | | AMENDE | | | | | | | 0 | 2d Data o | f dolinop/ | |
| Box 68760 e death certificate b the attending physice of for use as the bu | sician/Me | IF FEMALE: 23b. Was decedent pregna | ant in the | , , , , | s, outcome of pre | | etal death | 3 Ec | topic pregna | ancy | 2 | 3d. Date of Month | Day | Year |
| x 6. h cert tendir use a | ië Si | past 12 months? | - | 4 Pre | gnant at time of d | = | Other (Specify | y) | | | | | | |
| Bo e deat the at ed for | Phys | 1 Yes 2 No 9 | | 9011 | nown | | | | | 1000 (| Vid Aab aaa | a una cant | ributa to the c | ause of death? |
| P.O. es that the igned by | by P | Part II. Dther significant | | ns contributing | to death but not | resulting in the | underlying ca | ause given i | in Part I. | | | | | 4 Unknown |
| S, P.C uires that n signed l | 8 | Chronic alcohol | use | - | | | | | | | Vas an | | | findings available |
| cords, law requir has been s | Completed | | | | | | | | | 8 | utopsy performed | | | etion of cause of |
| Rec The la cate h | E | | | | | | | | | | 'es 2 | | 1 🗸 Yes | 2 No |
| Vital Rec ysiciau: The l his certificate director, page | Be | 25. Was case referred to examiner? | medical | [Hospital: | | | | Otho | eath (Check | | | | | |
| 'Yit | P | 1 ✓ Yes 2 | No | Hospital: 1 | Inpatient 2 | ER/Outpatie | | | 1 1 1 1 1 1 1 1 1 | ng Home 5 | ribe how it | | ✓ Other: Sce | ene |
| n of ling Pl | | 27. Manner of Death 1 ✓ Natural 5 | _ nd: | (Mo | te of Injury nth, Day,Year) | 28b. Time of | | c. Injury at \ | | 280. Desc | inde now n | njury occur | | |
| Sion of Attending Ph. Tr death. Tector: After the funeral | l ặ | 2 Accident | Pendii Invest | igation | one of Injury At | homo form str | | | | 28f Locat | ion (Street | and Num | ber or Rural R | oute Number, City |
| Division of Vital Records, pital or Attending Physician: The law requir ours after death. eral Director: After this certificate has been s filled in by the funeral director, page 2 should I | ertification: | 3 Suicide 6 | Could | not be | ace of Injury - At | nome, raim, Str | oci, raciory, u | ANGE DUNUIT | .g, oto. | | wn, State) | | | |
| fil ou | 0 | 4 Homicide 29a. Certifier (Check only) Certifier | fying Ph | vsician: To the b | est of my knowle | edge, death occ | curred at the ti | me, date ar | nd place, an | d due to the | cause(s) | and manne | er as stated. | |
| To the Hos within 24 h To the Fur completely | edical | one) 2 Media | | niner: On the bas and manne | is of examination r stated | and/or investig | | | | at the time, | | | | |
| F 3 F 8 | ĕ | 29b. Signature and title o | f certifier | 10 | | | | License nur | | | 1 | _ | ned (Month, i | Day, Year) |
| | | () 0 11 | 101 |) 10 L 1M | 0 | | | O.C.M.E | | | Se | eptembe | er 3, 2008 | |
| 10 | _ | 30. Name and address of | | | | | 14.5 | hand 5 | Itima | 4D 0400 | | | | |
| 1 | | Donna M. Vince | nti, MD |) Assistan | t Medical Exa | aminer 11 | 11 Penn S | reet, Ba | iumore, N | AID 7 150, | l . | | | |

State Registrar

SEP 0 8 2008

Registrar's Signature

ORIGINAL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ELORES ARMOUR OY /Medical 4b. City. Town. or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's 3637 Elder Oaks Boulevard # 8310 Bowie 8. Date of Birth (Month, Day, Year) 11-24-1946 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Country) Wash.,DC 577-62-4811 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location or Items 23a or 28a-f show aminer must be notified at 1)⊟Yes 2 No Directo Maryland | Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3637 Elder Oaks Boulevard #8310 20716 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Jackson Roullette McNeal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3637 Elder Oaks Blvd. #8310 Bowie,MD 20716 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra Lance Armour/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 08-08-2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility MO1246 21. Signature of Funeral Service Licensee Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 Vac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an ate has page 2 s this certificate 1∐ Yes 2 N No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the To the Hospital o within 24 hours aft To the Funeral D

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of centifier

30. Name and address of person wind completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

un

SEP 08 2008 29c. License number

DEFENSE HIGHWAY ANNAPONMONING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ 0 0 8 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Year **Physician** 2323 Jaylen Driscoe 09 01 Carrie 2008 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Battimore Center 1 Year Medical University of Maryland If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1 ☐ M 2 💢 F Vrs Director 09 01 2008 MD N/A
Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic excent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore **Funeral Director** MD NA 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 1500 West Lexington Street 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2√☐ No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sharelle Murphy Jeffrey Briscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type, Print) 1500 West Lexington Street, Baltimore, Sharelle Briscoe-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/08 Woodlawn, Md King Memorial Park 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Fina! disease or condition resulting in death) Prematun a Extreme Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24a. Was an autopsy performed? 2,4NU 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No aftar death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 Lalger MD

State Registrar

2008

Alissa

31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)



MD

S.

22

D26741

Greene St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10b per fh 8883 9-8-08 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death . Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Year O Month Physician 10:45 AM /Medical Name (If not institution, give st 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Kiche If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, urity Number Birthplace (State or Foreign
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(Give kind of work done during most of working flife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be vene မ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blue 21216 Avenue Walbrook talto, Ma. 21211 20c. Location - City or Town, State Ma Michael Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Farmham. Greene Funeral Sorvices 21. Signature of Funeral Service Lice 22. Name and Address of Facility _MO1401 5151 Hallimire Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of). disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and that the death certificate be executed Due to (or as a consequence of) physician a 68760. Physician/Medical attending p for use as t P.O. Box IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Virgina s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use cop fibute to the cause of death? Records, þ 2 🖸 No β ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No Were autopsy findings available prior to completion of cause of death? cate has t page 2 s After this certificate funeral director, page Division of Vital 1 Wes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Dother (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending neral Director; A 1 □Yes 2 □No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determi 4 Homicide To the Funeral 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certification completed cause of death (Item 23a) (Type, Print) 32. Registrar 31. Date filed State Registrar

913/08

O. Youn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Baby Girl Blick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Min. (Month, Day, Year) 51 Aug 24, 2008 5. Social Security Number If Under 1 Year If Under Months Days Hours Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 💢 F infant Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 27 No Cockeysville Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21030 USA 603 Cranbrook Road #E by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or her any injury or other transment. Black White etc 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Barbara Blick ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4□Donation 5☒Other (Specify) in state 21. Signature of Europeal Service Licensee Ronald S. Wage, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1. Enter the viseas, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** MINY disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: 4 \sum Nursing Home Hospital: 1 X Inpatient 1 🗌 Yes 3 🗆 DOA 5 Residence 6 Other (Specify) 2 ER/Outpatient ည 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 24 hours after death. P Funeral Director: After I Pending investigation injury 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital 29a. Certifier (check only Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the the 29b. Signature and title of certifier 29c. License number . 29d. Date signed (Month, Day, Year) Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATHEW 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 08 2008 Registrar

DHMH 17 Rev 1/2001

Records, P.O.

Division of Vital

| | | | 1 - For State Registrar | State of Marylan | d / Depa <i>Cer</i> | artment of H <i>tificate of L</i> | lealth and M Death | | eg. No. | 08 | 28641 | | |
|---------------------------------------|--|----------------|---|---|-------------------------------|--|---|---|-----------------------------------|--------------------------------|--|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | st) | | | | 2. Date of Dear Month | th Day | Year | 3. Time of Death | | |
| × | /Medic | cal | Baby Boy Bah 4a. Facility Name (If not institution, give | street and number) | | 4b City Town or | Location of Death | Chiquest | 4c. County | of Death | 1637 M | | |
| | Examin | ier | The Johns Hopkins H | • | | Baltimore City | | | | | | | |
| I | Funeral Director | | 5. Social Security Number 6. Sinfant 1 | <u> </u> | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs | 8. Date of Birth (Month, Day, Aug 22, | Year) 2008 | 9. Birthpla Country Mary | ace (State or Foreign | | |
| | land ow <u>t</u> | | Usual Residence of Decedent 10a. State 10b. County | unk 10c. City | , Town or Lo | cation | | | | 10 | d. Inside City Limits | | |
| | e Mary Ra-f sh ffled a | ctor | WV | Ma | rtins | ourg | | | | | 10d. Inside City Limits 1 Yes 2 No intry? ican Indian, , etc. lack Idack Industry Industr | | |
| | vith the | Director | 10e. Street and Number | | | 10f. Zip-Code | | 1 | 0g. Citizen of W | | y? | | |
| | death with the Maryland ims 23a or 28a-f show must be notified at | Funeral | 108 Ganguin Drive | 12. Was Decedent Ever in U.S | i. 13. V | 25603 | | ecify Yes or No- | USA 14 Bace | | n Indian | | |
| 2-0036 | within 72 hours after sne. than "natural", or Ite te Medical Examiner | þ | 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | ' | f Yes, specify Cuba I □ Yes 2∑ No | ispanic Origin? (Spen, Mexican, Puerto Specify: | Rican, etc.) | | k, White, et | C. | | |
| -6121 | | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) infant | ducation de completed) College (1-4 or 5+) infant | (Give life. L | dent's Usual Occup kind of work done o DO NOT use retired, infant | during most of worki | ing | infan | | ıstry | | |
| N | filed v Hygie other t | | 17. Father's Name (First, Middle, Last) | Illiant | | Intant | 18. Mother's Name | e (First, Middle, | | | | | |
| land | Aental Aental rked c | To Be | Mamadou Bah | | | | Marian | Bah | | | | | |
| | s 1 and 2 should be f f Health and Mental H Item 27 is marked of other traumatic ever | | 19a. Informant's Name/Relationship (7 The Johns Hopkins | | 19b. Mailir 600 I | ng Address (Street A. Wolfe | and Number or Run Street Ba | al Route Numbe 11 ti more | , City or Town, MD 2 | State, Zip 0 1287 | Pode) | | |
| Imore, | permit. Pages 1 ar Department of Hee Important: If Item any Injury or other once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 📉 Other (Specify | Removal from State of | emetery, cren | sition (Name of natory or other plac | e) ¦ | | 20c. Location - | | | | |
| Balt | permit. Depart Import any Inj once, | | 21. Signature of Kunera Service Licens | are | В | altimore, | omy Board MD 2120 |)1 | | ore S | treet | | |
| | | | a. P rt 1. Enter the disease, or comp shick, or hear ailure. List only of Immediate Cause (Final | blications that caused the death one cause on each line. | . Do not ente | er the mode of dyin | g, such as cardiac | or respiratory arr | est, | | Interval Between Onset and Death | | |
| ä | Physician /Medical | | disease or condition resulting in death) | a. Due to (or as a conse | ence of) | plasia | | | | M | inutes | | |
| | Examiner | ner | Sucure fielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Extreme Due to (or as a consequence. Multiple | ence of): | terine gr | owth res | triction | S | m | whates | | |
| | ficate be executed physician and as the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Multiple Due to (or as a consequ | ence of): | inital | anoma (i' | 25 | | m | inutes | | |
| 8/00, | ate be e nysician the buri | edical | | d Prematur | ity | | | | | m | inutes_ | | |
| 0 X | certifica ding pl | | IF FEMALE: | 23c. If yes, outcome of pregna | ncy | | | | 22d Dat | e of deliver | | | |
| .C. BOX | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physician/N | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown | death 3 [| Ectopic pregnancy Other (specify) | / | | Mor | | | | |
| cords, r | quires that in signed b | ρ | Part II. Other significant conditions of | ontributing to death but not resu | ulting in the u | nderlying cause giv | ven in Part I. | 23e. Did to | | | | | |
| al necc | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director. | Completed | | , | | | | 24a. Was ar autops perforr 1 2 Yes | y ned? | prior to com death? | sy findings available apletion of cause of | | |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | slcian: certific irector | Be c | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatient 2 | ER/Outpatient | Othe | 26. Place of Death | | | er (Specify) | | | |
| 5 5 | ding Phys h. After this funeral d | tion: To | 27. My ner of Death 11 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury Work | / at | 28d. Describe ho | | | - | | |
| DIVISION | il or Atten after deal Director; d in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of injury - At hor building, etc. (Specify, | me, farm, stre | eet, factory, office | | 28f. Location (Si City or Town | | er or Rural | Route Number, | | |
| | ne Hospitz n 24 hours ne Funeral pletely fille | edicai (| 29a. Certifier 1 Certifying Phyone) 2 Medical Exam | ysician: To the best of my know niner: On the basis of examinati and manner stated. | ledge, death on and/or inv | occurred at the tim restigation, in my of | ne, date and place, pinion, death occur | and due to the cred at the time, c | ause(s) and ma late and place, | nner as sta and due to | ted. the cause(s) | | |
| | within com | ž | 29b. Signature and title of certifier | 1 10 | | 29c. License | . 5 | 2 | 9d. Date signed | | | | |
| | | | 30. Name and address of person who | ompleted cause of death (Herr | 23a) (Type | | 0-1628] | | Lugust | 22, 8 | 2008 | | |
| _ | | | Collean Hug | hes Priscoll | | | 600 1 | North Wol | fe St, Ba | ltimore | , MD, 21287 | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) SEP 0 8 200 | S2. Registrar's Signat | ire Appar | w | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AM Year **Physician** CANNON THELMA 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country). 7. Age (In yrs. last birthday) Funeral Days Min. Year 1 □ M 2 🔽 F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Event here, not by notified at 1 XYes 2 □ No **Funeral Director** timore 10g. Citizen of What Country? Apt. 227 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 215-0036 1 ☐ Yes 2 No Specify. Be Completed by 3 Widowed 4 ☐ Divorced Blac Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event, I'm Med any injury or other tra Elementary/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) herrin Bapt Church Cem. 22. Name and Address of Facility
JOSEPH L. RUSS FUR
2222 W. North Ave. 21. Signeture of Funeral Service Licenses Funeral Home, ve. Balto. Md. 23a. Pa / Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADVANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury iner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transi Exami BUS GAS G and CORON ARY that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) been signed by the s should be detached t 1 ☐ Yes 2 🕱 No Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 1 ☐ Yes 2 X No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending 1 🔀 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

ADEYEMIS

31. Date filed (Month, Day,

SEP U 8 2008

M.0

32 Registrar's Signature

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DLD COURT ROAP, RANDALISTOWN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death RATCH 135 AM 2008 4c. County of Death ity Name (If not institution, give street and number) 4b. City, Town, or Location of Death mari 6 S If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number (In yrs last birthday) Hours Min 1 ☐ M 2 👿 F 243-50-2967 6-20-1933 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 res 2 No Ballimore 10e. Street and Number 10g. Citizen of What Country? 21239 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Black 3 ☐ Widowed 4 🌠 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Moore 19a, Informant's Name/Relationship (Type. Print) dauchtw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8200 Hoore rarline 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) - 2008 21. Signature of Funeral Service Licensee 1701 Ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPSIS days disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injuthat initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident

Physician /Medical Examiner Examiner

be executed

P.0.

Records,

of Vital

Division

To the Hospital or Attending Physician:

within 24 hours

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be ပ

Funeral

Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical

Completed by

Medical Certification: To

burial-tran and physician the attending properties for use as use as the 8 signed by to page 2 s this certificate After this funeral c To the Funeral Director; completely filled in by the

5 Pending investigation

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

BLVD BALTIMORE, MD 21239

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check onlone) 29b. Signature tirle of certifie

6 ☐ Could not be

CED 0 8 2008

1SICIAN

29c. License number 00051024 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. KOMEUS, M. D. 57601 LOCH RAVEN 31. Date filed (Month, Day,

3 Suicide

29a. Certifier

4 ☐ Homicide

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Helen M. Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fahrney Keedy Memorial Home Washington Roonsboro 8. Date of Birth (Month, Day, Year) Sept 24, 1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1 □ M 2 V F Maryland 83 182-22-5131 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Washington Smithsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 Blue Mountain Estates 21783 USA Funeral unk 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. footwear factory worker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Engler Kipe Agnes Mattalene McClain 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Fishack/daughter 13134 Bikle Road Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4K Donation 5 ☐ Other (Specify) Je Wad of Euneral Ser Rona L State and accompanion of 55 W. Baltimore Street Director 21201 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Discase COTONAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Paramonia Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy performed certificate 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Box 68760, Division or Vital Records, P.O.

3altimore, Maryland 21215-0036

Physician: or Attending death after To the Hospital

completely filled in by the funeral Director: within 24 hours a

> State Registrar

Medical

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cf

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a, Certifier

7060396

09/01/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURSHED

ARID 31. Date filed (Month, Day, Year) SEP 0 8 2008 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

AUGUST

CHAMBERLAIN P.O. I Records. Vital o Division

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 30, Paul E. Chamberlain August 2008 8:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Baltimore Lutherville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 5, 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 7. Age (In vrs. last birthday) 1930 78 022-22-5104 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examine in using the notified at once. 1 ☐ Yes 2√ No Director Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 414 Ellis Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?
12 Yes 2 No
14 Yes, Give
Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white þ 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) consultant pensions 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis L. Chamberlain Antoinette J. Desautels ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 84 Morans Avenue Fawn Grove, PA 17321 Janice Bowman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Si nature Ronal Serice Licensee Ronal S. Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a LIVER CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed the burial-trar Due to (or as a consequence of): attending physician for use as the hirial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy page 2 The 1 ☐Yes 2 No Physiclan: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after deatl To the Funeral Director; 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number PNITTON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Malonie 2008 ZO 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Vear If Under 24 Hrs. Maryland Medical 8. Date of Birth (Month, Day, Aug 20, 9. Birthplace (State or Foreign 1 □ M 2 🗑 F ^Y2008 Aug Maryland infant Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11918 Dalewood Drive 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No black Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Megan Tharp Malo S. Esper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 22 S. Greene Street Baltimore, MD University of Md Med Ctr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Euroral Service Licensee Ronal Processing Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore. _MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prematrit resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown

Physician /Medical **Examiner**

and

physician

permit. Pages 'Department of H Important: If ite any injury or ot once,

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or here is a notified at ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner use as the burial-tran funeral director, page 2 should be detached for Be Completed by Certification: To

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

| Part II. Other significant conditions | contributing to death but not res | sulting in the underlying o | ause given in Part I. | 23e. Did tobacco use contribute to the cause of death? | t . | | |
|--|---|---|---|--|-----|--|--|
| Molar Przgnance | at 21 wec | ks gestation | On | 1 Tes 2 No 3 Probably 4 Unkno | wn | | |
| | | | | 24a. Was an autopsy performed? 1□ Yes 2 No 1 24b. Were autopsy findings availa prior to completion of cause death? 1□ Yes 2 No 1□ Yes 2 No | | | |
| 25. Was case referred to medical | | | ath (Check only one) | | | | |
| examiner? 1 ☐ Yes 2☐ X No | Hospital: 1 npatient 2 | ER/Outpatient 3 DC | me 5 ☐ Residence 6 ☐ Other (Specify) | | | | |
| 27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident investigation | | 28b. Time of Injury M | 28c. Injury at Work? 1 ∐ Yes 2 ∐ No | 28d. Describe how injury occurred | | | |
| 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | | ome, farm, street, factor | y, office | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier 1 Certifying Pl | nysician: To the best of my kn miner: On the basis of examin | owledge, death occurred ation and/or investigation | at the time, date and place | e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s) | | | |

29c. License number

6545

29d. Date signed (Month, Day, Year)

8/20/08

Baltimore MD 21201

State Registrar

Medical

29b. Signature and title of dertification

31. Date filed (Month, Day, Year)

SEP 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S Tara Dennis

2008

32 Registrar's Signature

within 24 hours a To the Funeral I Hospital

| • | | Please Type or Print in I | Black Indelible In | k. Ensure Al | I Copies A | re Legible. | | | |
|--|-------------------|---|--|---|--------------------------------------|--|---|--|--|
| | | 1 _ State | nd / Department of Certificate o | | | 2002 | 28647 | | |
| | | Registrar 1. Decedent's Name (First, Middle, Last) | - Continuate of | Death | 2. Date of Death | g. No. <u>C</u> U U U | 3. Time of Death | | |
| Physicia /Medic | | James Henry Fant | | | September | Day Year | 8 023 a M | | |
| Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City Town | or Location of Death | 1 | 4c. County of Death | | | |
| | | Union Memorial Hospital | Kal- | HMOre | 0.00 | | | | |
| Funeral Director | | 5 Social Security Number 6. Sex 1 Age (In yrs. | last birthday) In Under 1 Yea Yrs. Months Day | | 8. Date of Birth | Year) 9. Birti | hplace (State or Foreign untry) | | |
| ъ | | Usual Residence of Decedent | | | 7 10 | 20 | | | |
| arylan show d at | ř | 10a. State 10b. County 10c. Ci | ity, Town or Location | | | | 10d. Inside City Limits 1 XYes 2 □ No | | |
| the Ma 28a-f lotifie | Director | 10e. Street and Number | UTIMOVE | | 10 | g. Citizen of What Co | / | | |
| aa or | Ö | 1214 N Bentalau Strat | 10f. Zip Code | 116 | 10 | 115A | unitry: | | |
| death | Funeral | 11. Marital Status 12. Was Decedent Ever in U | I.S. 13. Was Decedent o | f Hispanic Origin? (Spuban, Mexican, Puerto | ecify Yes or No- | 14. Race - Ame | | | |
| after or Ite | | Armed Forces? 1 □ Never Married 27 Married 1 □ Nes 2 □ No If Yes, Give | 1 □Yes 2 N | | rican, etc.) | Black, White | e, etc. | | |
| hours tural" | ed by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | 16a. Decedent's Usual Occ | | | Ca | ack | | |
| in 72 n "na" | plet | 15. Decedent's Education (Specify only highest grade completed) | | ne during most of worki | | 6b. Kind of Business/l | maustry | | |
| d with | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | Tester | | | hemistri | 1 Lab | | |
| be file tal Hy d oth event | Be | 17. Father's Name (First, Middle, Last) | | 18. Mother's Name | e (First, Middle, Ma | aiden Surname) | | | |
| 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Marical Evaminer must be notified at | _C | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mailing Address (Stre | Ellar | 10e 600 | 20Ker | Zin Codo) | | |
| and 2 s lealth ar m 27 is ner trau | | Frances Fart Wife. | 1214 N. 20 | Malou St | wot P | nito M. | 7.17.69 | | |
| ss 1 a of Hear | | | Place of Disposition (Name of cemetery, crematory or other p | | Date 2 | 0c. Location - City or | Town, State | | |
| Pages ment of ant: If it | | 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | een Mount | 4-8- | -08 | 3alti Mor | e, Md | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaminer must be notified at once. | | 21. Signature of Funeral Service Licensee | 22. Name and Add | dress of Facility VQV | ghn C. G | reene Fune | . 4 4 - (2) | | |
| 452 4 4 | | 23a. Part 1. Enter the disease, or complications that caused the dea | th. Do not enter the mode of o | MORE NOTE | or respiratory arre | Ke Etalto | Approximate | | |
| Physician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | | or respiratory arres | ν, | Interval Between Onset and Death | | |
| /Medical | | disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | |
| Examiner | | Sequentially list conditions b. Critical | Aortic Stene | عادن | | | 13 days | | |
| Si / Ted | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence of): | | | | | | |
| an and rial-transit | Examiner | that initiated events resulting in death) Last C | | | | | | | |
| icate be physician the buri | _ | L _d | | | | | | | |
| ing ph | Medi | IF FEMALE: | | | | | | | |
| eath certific attending p for use as | ian/l | 23b. Was decedent pregnant 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet. | al death 3 Ectopic pregna | | | 23d. Date of del | ivery Day Year | | |
| The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur | Physician/Medical | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown | death 5 ☐ Other (specify) | | | | 22, | | |
| es that igned b | by Pr | Part II. Other significant conditions contributing to death but not res | sulting in the underlying cause | given in Part I. | 23e. Did toba | acco use contribute to | the cause of death? | | |
| w require been sig should b | ed b | Hypertension, hyperlipide | mia | | 1 ☐ Yes | ; 2 □ No 3 □ 6r | obably 4 Unknown | | |
| law range be | Completed | · | | | 24a. Was an autopsy | | itopsy findings available completion of cause of | | |
| | | | | | perform | ed? death? ☐No 1 ☐ Yes | | | |
| siciar certif | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Monatient 2 | 3500 | 26. Place of Deatl | | | | | |
| ding Phys h. After this funeral dir | n:T | 27. Manner of Death 28a. Date of Injury | 28b. Time of 28c. In | 4 LI Nursing Ho | me 5 ☐ Resider 28d. Describe hov | nce 6 □Other (Spe v injury occurred | cify) | | |
| endin sath. or: Aff he fur | atio | 1 Matural 5 Pending (Month, Day, Year) 2 Accident investigation | | □Yes 2 □No | | | | | |
| or Attending Physician: after death. Director: After this certific in by the funeral director, I | Certification: To | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Spec. | nome, farm, street, factory, officity) | е | 28f. Location (Stre City or Town, | eet and Number or Ru State) | ural Route Number, | | |
| Hospital 24 hours a Funeral D | | 29a. Certifier 1 Certifying Physician; To the best of my kn | owledge death occurred at the | time date and place | and due to the ca | use(s) and manner a | e stated | | |
| To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical | | | | | | | | |
| To th withir To th comp | Me | 29b. Signature and title of certifier | 29c. Lice | ense number | 29 | d. Date signed (Mont | h, Day, Year) | | |
| } | | Slephen/Guys 1 | 1.0 00 | 0063163 | 5 | ptember 2 | 12648 | | |
| 12 | | 30. Name and address of person who completed cause of death (Ite Stephen Nysyen, NO Unish Menania | m 23a) (Type, Print) | st V | Parell more | Reltimore | MO 2/2/8 | | |
| Sta | te | 31. Date filed (Month, Day, Year) 32 Registrar's Sign | ation and/or investigation, in m 29c. Lice 29c. Lice 29c. Lice 29c. Lice 29c. Lice 29c. Lice 29c. Lice 29c. Lice | רוושנוגע וכי | 7 | | | | |
| Registr | | SED 0 8 2008 12 12 1 | 4 Speaker | | | | | | |

08-06343 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Laurence Griffin State of Maryland / Department of Health and Mental Hygiene 2008 28648 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1304 hrs Laurence Glynn Griffin Medical Examiner August 19, 2008 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Malcolm Grow Hospital Camp Springs If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6 Sex **Funeral** Country)A Days Months Hours 74 2, 193 Apr. Director 206-26-6244 1 X M · 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 X No Camp Springs Prince George Marvland "natural", or items 23a or 28a-f sho Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? USA 20735 ō Auth Road 5121 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-4. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1X Yes 2 Never Married 2 Married Black 4 X Divorced Yes 2X No specify: Specify D 21215-0036 should be filed within 72 hours after and Mental Hygiene. f Yes, Give Year ρ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Air Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "
or other traumatic event, the Medical. 12th grade Force 8. Mother's Name (First, Middle, Maiden Surname)
Faye McCray 17. Father's Name (First, Middle, Last) Saul Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4784 Sheffield Circle Waldorf, Maryland20602 19a. Informant's Name/Relationship (Type, Print) Derrick Joseph/ Grandson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Place of Dispusion (crematory or other place) 9/9/08 1 X Burial 2 Cremation 3 Removal from State Cheltenhem Cheltenham, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Chatman-Harris Funera 5240 Reisterstown Rd Baltimore, Md 21. Signature of Funeral Service Licensee rou Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ailure. List only one cause on each line. /Medical Death a. Exsanguination Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Aprtic Dissection Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause c. Hypertensive Atherosclerotic Cardiovascular Disease (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Live birth Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown а Unknown the 23e. Did tobacco use contribute to the cause of death? o. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I ⋧ Yes 2 No 3 Probably 4 V Unknown of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page ✓ Yes ✓ Yes 2 2 No 26 Place of Death (Check only one 25. Was case referred to medical Be Other₄ Hospital: 1 examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 1 Yes this ۵ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification ✓ Natural Yes 2 Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Suicide Could not be or Town, State) determined To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 20, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:00 A M ALBERT C. GANNAWAY JR. August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UNION MRMORIAL HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 9. ARKANSAS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**™**M 2□ F 430-03-9409 88 **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Marylanc 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show Exactions coust by notified 1 Yes 2 □ No Director N.Y NEW YORK 10g. Citizen of What Country? 10e. Street and Number 188 EAST 64TH STREET 10021 USA items 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Nes 2 No If Yes, Give Year or Dates: WWI 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If I.M. Elementary/Secondary (0-12) 4YRS PRODUCER/DIRECTOR PRODUCER/DIRECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALBERT C. GANNAWAY SR. ANNE V. YANCEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32835 TYRONE YOUNG(STEP SON) 3285 LAKE DEBRA DR. BUILD. 23-107 ORLANDO, F 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY08/30/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. JENKINS & SONS CO. YORK RD MONKTON, MD. 2 HENRY W. 16924 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 WKS neumonic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner clostrialum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine i or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Year)

29b. Signature and title of certifier

30. Name



and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept. 1, 2008 **Physician** 1:10p M Irene Ε. Holbrook /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase 202 Primrose Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 🖵 F Days Milford, MA. 88 225-46-3369 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Chevy Chase Μđ Montgomery 1 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 2 should be filed within 72 hours after death with in and Mental Hygiene.

is marked other than "natural", or items 23a or USA 20815 202 Primrose Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 📉 No Specify Specify þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Delia Moriarty Charles Joslin ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar 202 Primrose Street Chevy Chase, Md 20815 Health a Roberta Martin/Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ☐ Cremation 3 ☐ Bemoval from State 5 ☐ Other (Specify) 1 Burial Cremation
4 Donation 5 Other (Vernon Grove Cem. 9/06/2008 Milford, MA. 21. Signatu PATLIP D'RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4days Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lymphoma 19mo. Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2**X** No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medica examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral D 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sept.1,2008 D0034742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Umhau MD 3301 New Mexico Ave. N.W. Washington, D.C. 20016 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

SEP 0 8 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Junior A. Cuellar-Hernandez 2008 28651 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day August 30, 2008 Cuellar -Hernandez Alberto 1801 hrs Junior **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville Shady Grove Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Collaryland Hours Min. 9/27/2007 218-79-8667 Director 1 X M 2 F Yrs. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a, State 10b. County Gaithersburg 1 X Yes 2 No MD Montgomery 28a-f show must be notified at once. with the Maryland Director 10g, Citizen of What Country 10e. Street and Number 10f. Zin Code 20877 USA 531 South Frederick Ave.#302 or items 23a or 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
Honduran Armed Forces' death 1 X Never Married 2 Married 2 X No Yes White No specE:1 Salvador Specify If Yes, Give Year 1 X Yes 2 Widowed Examiner Divorced "natural", à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical I Baltimore, MD 21215-0036 none none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delmis Hernandez Carlos Cuellar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town) Address (Street and Number or Rural Route Number, City or Town) 19a. Informant's Name/Relationship (Type, Print) 531 South Frederick Ave #302 Gaithersburg Delmis Hernandez/Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/09/2008 Germantown, Md All Souls Cem. Other Specify Donation 5 21. Signature of Funeral Service Licenses PHTCTP D.RTMALDI FUNERAL SERVICE P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death X-Link myotubular myopathy Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a,27, per ME g885 11/21/08 TT Physician/Medical X UNPENDED physician the burial -Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day 1 Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy death? performed? Yes 2 ✓ Yes certificate the Hospital or Attending Physician: 'thin 24 hours after death.

the Funeral Director: After this certific upletely filled in by the funeral director, I 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ို 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) within 24 hours a To the Funeral I determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number September 4, 2008 O.C.M.E. 30. Name and address of person who complete cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

State of Maryland / Department of Health and Mental Hygiene 28652 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 08 **Physician** 0831 A M MICHAEL 0 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOLE NLA OF MARYLAND MEDICAL LEWTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Min 1 X M 2 ☐ F 02/15/1982 Director 220-04-7136 26 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. Count 10c. City, Town or Location 23a or 28a-f show Department of Health and Mental Hygiene. Important: or items 23a or 28a-1 show important: if item 27 is marked other than "natural", or items 23a or 28a-1 show almost night of the rectified at once. 1 ☐ Yes 2 No Director Baltimore Middle River MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2210 Graythorn Rd. 21220 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. ☐Yes 2 XNo 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify Specify: White If Yes, Give þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Barge Runner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dawn Marie Lewis ပ Hamm Bruce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2210 Graythorn Rd. Baltimore, MD 21220 Robert Garner (stepfather) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp 09/08/2008 Towson, Maryland ↓ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of 21. Signature of Funeral Service Licensee Dundalk, MD. 21222 Dundalk, Inc 7922 Wise Ave. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subduzl hemotoma **Physician** with uncel hour /Medical Due to (or as a consequence of): **Examiner** head truma Blunt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical EXAMINER 3 Ecopic pregnancy
5 Other (special) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death Month Year Day Ö 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) Injury 1 □ Natural 5 Pending 1 ☐Yes 2 XNo (ollision Motorcycle investigation 09/02/08 2 Accident 3 Suicide within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 406 poplard Street Street, Baltimore, MD 1406 popland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruch 22 S. Green aura 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| | | 1- For State Registrar | Cen | tificate o | f Death | | Re | | 0 2000 | | |
|---|----------------|--|--|------------------------|---------------------------------------|--|---|-----------------------------------|--|--|--|
| Physicia | ın/ | 1. Decedent's Name (First, Middle,La | | | 7 | | 2. Date of Death | Day Year | 3. Time of Death 0224 hrs | | |
| ledical Exami | ner | Zachary 4a. Facility Name (if not institution, g | Alan | | Harrisc | | September | 4, 2008 4c. County of Deal | | | |
| | | Liberty Road @ Abbie Pl | | | Baltimore | Location | , | Baltimore Co | | | |
| Funeral | | 5. Social Security Number 6. 9 | Sex 7. Age (In yrs. la | st birthday) | If Under 1 Ye | | | (MM/DD/YYYY) 9. Bi | | | |
| Director | | 21 00 1200 1 | M 2 F 50 | Yrs | Months Day | ys Hours | Min. 09 0 | 8 57 Forei | puntry) MD | | |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City | | | | | | | | | |
| š | ٦ | MD NA | | Bal | timore | | | | 1 XYes 2 No | | |
| Maryla 28a-f d to | ector | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of What Co | untry? | | |
| th the Maryland 23a or 28a-f sho | Dire | 6005 Prince Ge | | | | 1207 | | U.S.A. | | | |
| ath wi | unera | 11. Marital Status 1 Never Married 2 X Marrie | 12. Was Decedent Ever in U.S Armed Forces? | 5. 13. Wa | as Decedent of H res, specify Cuba | ispanic Origin? ın, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | 14. Race - Ame White, etc. | rican Indian, Black, | | |
| fler de | ш | 3 Widowed 4 Divorce | 1 Yes 2 No | 1 | Yes 2X N | specify: | | Specify: B | lack | | |
| ours a | d by | 15. Decedent's Education (Specify | only highest grade completed) | | nt's Usual Occupa | | | 16b. Kind of Business Pitts O | | | |
| 36 in 72 h han "r fical E | plete | Elementary/Secondary (0-12) 10th grade | College (1-4 or 5+) | | uck Dri | | 770.1100) | Express | 110 | | |
| 5-0036 iled within 77 Hygiene. I other than | Comple | 17. Father's Name (First, Middle, Las | | | | | lame (First, Middle, M | | | | |
| 215 be file ntal H rked o | | Richard Jerome | | | | A PURIS - CONTRACTOR - CONTRACT | ier Cann | | | | |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f short craumatic event, the Medical Examiner must be notified at once | 의 | 19a. Informant's Name/Relationship Ella L. Harris | | 19b. Mailin | g Address (Stre 5 Princ | et and Number | ror Rural Route Num | ber, City or Town, State et, Balt | e, Zip Code) imore, Md | | |
| Baltimore, MD 2 pemit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumaric | | 20a. Method of Disposition | 20b. P | lace of Dispo | sition (Name of ce | | Date | 20c. Location - City of | | | |
| nore | | 1 NBurial 2 Cremation 3 | Removal from State | rematory or of udon | | ام | /9/08 | Baltimo | re, Md | | |
| Baltimore, permit. Pages I at Department of Hee Important: If ite | | 4 Donation 5 Other Special 2 Signature of Funeral Service Lice | ,, | | | | | | | | |
| E E E | | Myni D | Keh | | | | | imore, M | | | |
| Physician /Medical | | 23a Part I. Enter the disease, or confailure. List only one cause on | each line. | | | | | st, shock, or heart | Approximate Interval Between Onset and Death | | |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) | Atheroscleroti Due to (or as a consequence of | | iovascu] | lar dis | ease | | Death | | |
| _ | | Sequentially list conditions, | | | | | | | | | |
| | ine | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c. | | | | | | | | | |
| nd ansit | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of |): | | | | | | | |
| exection and and and and and and and and and an | | X UNPENDED | AMENDED o = | | - 224 42 | 10.100 - | _ | | | | |
| 760, Teate be est physician the burial | Medical | IF FEMALE: | AMENDED , PII, 27, 23c. If yes, outcome of pregn | perME mancy | g884 10, | /2/08 T | T | 23d. Date of delive | ry | | |
| | sician/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 4 Pregnant at time of dea | | etal death 3 | Ectopic pr | egnancy | Month | Day Year | | |
| Box 68 e death certif the attending ed for use as | ysic | 1 Yes 2 No 9 Unknow | I . — — | 5 O | ther (Specify) | | | | | | |
| that the d | y Phy | Part II. Other significant conditions | | sulting in the | underlying cause | given in Part I | | bacco use contribute t | | | |
| S, P.C uires that n signed to | ed by | <u>Diabetes melli</u> | tus | | _ | | _ | | obably 4 V Unknown | | |
| of Vital Records, g Physician: The law require. then this certificate has been sineral director, page 2 should to | Completed | | | | | | 24a. Was a autop: perfor | sy prior to | autopsy findings available completion of cause of | | |
| Rec The l ficate l | 힝 | | | | _ | | 1 Yes 2 | | | | |
| Vital Rec ysician: The his certificate | Be | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 | ER/Outpatien | | Other N | | Residence 6 V Oth | er: Scene | | |
| of V ig Phy: fter thi | <u>د</u> | 1 Yes 2 No 27. Manner of Death | | 28b. Time of | | ury at Work? | • | low injury occurred | | | |
| ion of tending Pheath. | ation | 1 X Natural 5 Pending 2 Accident Investiga | | | 1 | Yes 2 No | | | | | |
| Division tall or Attendi | Certification: | 3 Suicide 6 Could no determin | ot be 28e. Place of Injury - At ho | me, farm, stre | et, factory, office | building, etc. | 28f. Location (S or Town, St | | Rural Route Number, City | | |
| | 2 | 29a. Certifier | cian: To the best of my knowledge | ie death acci | rred at the time | tate and place | and due to the cause | e(s) and manner as et- | ated | | |
| To the Hos within 24 h To the Fur completely | edical | one) Certifying Physical Examin | er: On the basis of examination ar and manner stated. | nd/or investiga | tion, in my opinio | n, death occur | red at the time, date a | and place, and due to | the cause(s) | | |
| N F. E E S | Me | 29b. Signature and title of certifier | | | 29c. Licen | se number | | 29d. Date signed (M | • , | | |
| | | hy ho, i | C,W | | 0.0 | .M.E. | | September 4, 2 | 008 | | |
| ϕ | | 30. Name and address of person who Ling Li, MD Assistant | | | et, Baltimore, | MD 21201 | · · | | | | |
| | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Signatul | | or, Datamore, | | | | | | |
| Regist | | SFP 0 5 2008 | Side of the property | Sall Sall | | | | | | | |

08-06708 Patr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 28654

| icia Hall | | For State | te of Maryland | | ment of ficate of | | i Mental H | ygiene Reg. | No. | | |
|--|---|---|--|-------------------|-----------------------------------|---|---|--|---|--|--|
| Physician | | e qistrar . Decedent's Name (First, Middle,I | | | | | | 2. Date of Death | av Vear | 3. Time of Death | |
| dical Examine | r | Patricia Hal | | | | | . (5 | September 2 | 2, 2008 4c. County of Dea | 1000 hrs | |
| | 4 | a. Facility Name (if not institution, 6260 Foreland Garth Ur | | ·) | 4 | b. City, Town, or I Columbia | ocation of Death | | Howard | | |
| Funeral Director | | | 7. Ag | ge (In yrs. last | | If Under 1 Year Months Days | If Under 24Hrs Hours Min | For | Birthplace (State or eign Country)Michigan | | |
| any | _ | Usual Residence of Decedent 10a. State 10b. County | | 10c. City. To | own or Location | on | | | | 10d. Inside City Limits | |
| * | | MD Howa | rd | C | olumbi | .a | | | | 1 Yes 2 X No | |
| tor 28a-f sh | | Oe. Street and Number 6260 Foreland | Garth #D | <u> </u> | | 10f. Zip Code 21 | .045 | 10g. | Citizen of What Co USA | ountry? | |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. This marked other than "natural", or items 23a or 28a-f show natte event, the Medical Examiner must be notified at once. | Lanera | 11. Marital Status 1 X Never Married 2 Mar | 1 Yes 2 | | If Ye | s Decedent of His es, specify Cuban | , Mexican, Puerto | pecify Yes or No- Rican, etc.) | 14. Race - An White, etc | white | |
| 2 hours after "natural", Examiner | ⋧┞ | 3 Widowed 4 Divor 15. Decedent's Education (Special Elementary/Secondary (0-12) | rced If Yes, Give Year or Dates: fy only highest grade co College (1-4 or | | 6a. Decedent | 's Usual Occupat | sual Occupation (Give kind of work done f working life. DO NOT use retired) 16b. Kind of Business/Indu | | | | |
| 036 ithin 7. ne. r than | Completed | 12 | 5+ | | con | sultant | | | self er | mployed | |
| 21215-0036 Uld be filed within 72 l Mental Hygiene. marked other than ", r event, the Medie II | | 17. Father's Name (First, Middle, L William Earl Bi | | MD | | | | e (First, Middle, Ma ne1 Fu1to | | | |
| 2121 buld be fill Mental F marked ic event, | 0 00 | 19a. Informant's Name/Relationshi | | . PID | 19b. Mailing | Address (Stree | | Rural Route Numb | | ate, Zip Code) | |
| MD d 2 sho lth and n 27 is numation | | William Hall/ne | ephew | | | | | #2 Buffa | 10, NY 14 | | |
| s 1 am of Heal of Heal | | 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Tourier Spe | | State cre | ematory or other | ematory | Inc 9 | -15-08 | Baltimor | e, Md. | |
| Baltimo permit. Page Department of Important: injury or off | - 1. | 21. Sign, ture of Funeral Service L RO I d | icensee S. Wada, 101 | rector | 1 49 | y freger | ICK Kar | 212 ـــمه | 28 | of Maryland In | |
| Physician /Medical | 1 | 23a. Part I. Enter the disease, or failure. List only one cause of | on each line. | | | | such as cardiac | or respiratory arres | it, shock, or heart | Approximate Interval Between Onset and Death | |
| xaminer | Ì | Immediate Cause (Final disease or condition resulting in death) | a. Chronic Obstru | | | sease | - | | | | |
| | | Sequentially list conditions, | | | | | | | | | |
| | | | | | | | | | -24 | | |
| cuted nd transit | events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| e be executed sysician and burial - transit | edical | UNPENDED | x AMENDED 2 | | | fh g883 | 9-18-08 | vt | Look Bata of dal | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | 5 I | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 4 Pregnant | | 2 Fe | etal death 3 ther (Specify) | Ectopic preg | nancy | 23d. Date of del Month | Day Year | |
| BO) he deat the at hed for | 21 | 1 Yes 2 V No 9 Unki | 9 Stittlewit | | culting in the | underlying cause | given in Part I. | 23e. Did tot | pacco use contribut | e to the cause of death? | |
| ires that the signed by | | Diabetes mellitus, Gra | | atil but not res | salang in the | underlying oddoo | givoiriiri | 1 🗸 Yes | | Probably 4 Unknown | |
| Vital Records, hysician: The law require this certificate has been significate to page 2 should be | Completed by | | | | | | | 24a. Was a autops | ned? prio | | |
| Re(ificate | | 25. Was case referred to medical | | | | 26.Plac | e of Death (Chec | 1 Yes 2 | NO I | Yes 2 No | |
| /ital | o Be | examiner? 1 ✓ Yes 2 No | 111 | atient 2 | ER/Outpatien | t 3 DOA | Other Nur | sing Home 5 | Residence 6 | Other: Scene | |
| Division of Vital tales or Attending Physician: rs after death an Director: After this certifed in by the funeral director | - | 27. Manner of Death 1 ✓ Natural 5 Pend | | njury iy,Year) | 28b. Time of | · · · · · | ury at Work? Yes 2 No | 28d. Describe h | ow injury occurred | | |
| Division Attention and Director Illed in by t | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Rou or Town, State) | | | | | | | | or Rural Route Number, City | |
| Division of Nother Hospital or Attending Phywithin 24 hours after death To the Funeral Director: After to | Medical C | 29a. Certifier | nysician: To the best of miner:On the basis of e and manner state | xamination ar | je, death occu nd/or investiga | urred at the time, o ation, in my opinio | date and place, a n, death occurre | nd due to the cause d at the time, date a | and place, and due | to the cause(s) | |
| F W F S | Me | 29b. Signature and title of certifie | | | | | se number | | | (Month, Day, Year) | |
| | | No m | Dint, MD | | | 0.0 | .M.E. | | September 2 | , ∠000 | |
| | | 30. Name and address of person Donna M. Vincenti, MI | D Assistant Med | | | 1 Penn Stree | t, Baltimore, | MD 21201 | | | |
| Sta Registi | ate rar | 31. Date filed (Month, Day Year) | 2008 37 Regis | strar's Signatu | e Gos | de | | | | | |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 2, 2008 **Physician** 3:31 A M FRANCES WILCOX JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital 4b. City, Town, or Location of Death Examiner Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan 29, 9. Birthplace (State or Foreign Country) Connecticut 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 1932 76 044-24-4131 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2 No Director N/A Maryland Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 107 Ridgewood Road 21210 **USA** Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2万 Married 1 ☐ Yes 25 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ <u>Ellen</u> Raymond Andrew Wilcox 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Ridgewood Road, Baltimore, Maryland 21210 Richard T. Johnson, M.D. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important; If Ite any Injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 9/5/2008 Baltimore, Maryland 21. Signatu Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Peritoneal due disease or condition resulting in death) Due to (or as a consequence of): Sequentially list could be if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): CERTIFICATION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cardiovascu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 No

Physician /Medical **Examiner**

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show unt; If Item 27 is marked other than "natural", or Items 20 or 20 or 20 or 20 or 10

Baltimore, Maryland 21215-0036

Medical Certification: To Be funeral To the riceping a er death.

To the Funeral Director Af

To the Hospital or Atternating Physician: The law requires that the death certificate be executed

After this

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1/2 10% 0700 M 1 L 1 ☐ Yes 2 X No SUBJECT 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State)
107 Kich Wood Rd. Baltimet 6 Could not be determined 3 ☐ Suicide 4 Homicide Ham (29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who complete druse of death (Item 23a) (Type, Print) Erin M. Carney 400 N. Wolfe St. E 32. Begistrar's Signature

Carney, M.D

Carney



DHMH 17 Rev 1/2001

Baltimore, MD 21287

| | | For State Registrar | State of Ma | - | Department Certificate | | | | giene Reg. No. | | |
|---|----------------|--|---|--------------------------|---|--|----------------|----------------------------|----------------------------------|--|----------------------|
| | | 1. Decedent's Name (First, Middle, Last) | | | | | 1 | 2. Date of Dea | | '004 | me of Death |
| Physici /Medio | | Fred Janney | | | | | | eptem 4 | per 5 20 | 08 6 | 51 A M |
| Examir Funeral | er | 4a. Facility Name (If not institution, give 5 1 1 405 pi C 5. Social Security Number 6. S | a/of Ba | (In yrs. last bin | re Bo | Town, or Location of Lines 1 Year If Un Days Hou | Ore | 3. Date of Birt | 4c. County of th 9 | Death Birthplace (S Country) | State or Foreign |
| Director | | 219-16-3150 | M 2□F | 82 | Yrs. | 54,5 | M | arch l | 6, 1926 | Marýla | nd |
| yland now | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | - | | - | 10d. Insi | ide City Limits |
| e Mar | Director | Florida Charlott | :e | Port | Charlott | e | | | | |]Yes 2⊠No |
| with th | | 10e. Street and Number | | | 10f. Zip | | | | 10g. Citizen of Wha | at Country? | |
| ns 234 | Funerai | 11480 Willmingt | on Blvd. 12. Was Decedent B | ver in U.S. | | 3981 ent of Hispanic | Origin? (Spec | ify Yes or No- | | USA 14. Race - American Indian, | |
| 72 hours after death with the Maryland 72 hours of tems 23e or 28e-f ehow Jical Exercited must be notified at | by | 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates: | 0 | 13. Was Deced If Yes, spec | | | ican, etc.) | Specify: | White, etc. White | |
| ⊆ _ 3 | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | | | Decedent's Usua (Give kind of wor life. DO NOT us | k done during i e retired) | | 9 | 16b. Kind of Busin | ness/Industry | |
| filed with Hygiene. other than | | 10 | | | Self Er | nployed | | (Eiret Middle | Food Maiden Sumame) | | |
| y can ould be filed Mental Hyg arked otheratic evant, | Be c | 17. Father's Name (First, Middle, Last) Frederick Janne | o v | | | 10. M | | Janne | | | |
| to, wall yield yield the stand 2 should the alth and Men tiem 27 is marke other traumatic | 오 | 19a. Informant's Name/Relationship (Ty | | 19b | . Mailing Address | (Street and Nu | | | er, City or Town, St | ate, Zip Code) | |
| s 1 and 2 of Health a item 27 is | | Jennie Janney | Wife | 3 | 3562 Mil | l Green | Road; | Street | , MD 211. | 54 | |
| | | 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ P | emoval from State | 20b. Place of cemeter | Disposition (Namy, crematory or o | ne of ther place) | Da | te | 20c. Location - Ci | ty or Town, Sta | ate |
| permit. Page Department of Important: If any injury or | | 4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Septice License | | Lake V | lew Mem | . Park | 9-9-2 | 2008 | Sykesvil | le, Mar hwah Wi | yland |
| permit Departi Importany in | | 1011001 | 1100 | 10 | Funeral | l Home | of Cato | nsvill | shton Scle, Inc. | MD 21 | 228 |
| | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused | the death. Do r | | | | | | Appro Interv | ximate al Between |
| Physician | | Immediate Cause (Final disease or condition | Coron | arrar | terro | diseas | 50 | | | Onset | t and Death |
| /Medical Examiner | | resulting in death) | Due to (or as a | consequence | of): | 1 C | 4 | :- | | -14 | days |
| | ler | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last resulting in death last resulti | | | | | | | | 77 | Udys |
| cuted | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | Acu | te Re | nal fa | ilare | · | | | | |
| icate be executed physician and the burial-transit | | resulting in death) Last | Due to (or as a | consequence | of): | | | | | | |
| | edlcai | | J | | | | | | | | |
| The law requires that the death certifule has been signed by the attending tage 2 should be detached for use a. | Physician/Mo | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | | | | | | | | Year |
| quires that the signed by all the detail | by | Part II. Other significant conditions con | ntributing to death bu | t not resulting in | the underlying ca | ause given in P | art I. | 23e. Did t | obacco use contrib res 2 No 3 | ute to the caus | |
| Phyeician: The law requires to this certificate has been signeral director, page 2 should be. | Completed | | | | | | | 24a. Was autop perfo | rmegl? pri | ere autopsy find or to completio ath? Yes 2 N | n of cause of |
| Iclan: certifica ector, p | BeC | 25. Was case referred to medical examiner? | 1 | | | 26. P | Place of Death | | | | |
| | ပို | 1 Tyes 2 No 27. Manner of Death Natural 5 Pending | lospital: 1 Inpatie 28a. Date of Injur (Month, Day | y 28b. 1 | | 8c. Injury at Work? | 28 | | dence 6 Other | | |
| Atten r deat actor: by the | Certification; | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubulding, etc | | | | | or Rural Route | e Number, | | |
| Hospita 4 hours Funaral tely filled | icai | (Check only 2 Medical Exami | | examination an | d/or investigation, | in my opinion, | death occurre | d at the time, | date and place, an | d due to the ca | |
| To the Hos within 24 ho To the Fun completely | Me | 29b. Signature and title of certifier | | | 290 | . License numb | ber | | 29d. Date signed (| Month, Day, Y | 'ear) |
| \ | | Af Sezu | eira, R | 1. D. | D | 00147 | 26 | - | September | + 5 20 | 08 |
| VX, | | 29b. Signature and title of certifier Alexandro Seg 31. Date filed (Month, Day, Year) SEP 0 8 2008 | empleted cause of de | eath (Item 23a) | (Type, Print) | 1,00 | ovo R- | Iti | - MA | _7/ | 715 |
| Sta | ite | 31. Date filed (Month, Day, Year) | 22. Registra | r's Signature | Rock . | 1veq 4 | 178 | ((L)one | Dre / 14 | 010 | 70 |
| Regist | rar | SED 0 8 2008 | Alle 160 | D' A | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. If G883 9/18/08 TT State of Maryland / Department of Health and Mental Hygiene 0 8 Amend 19a, perINf G883

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 24, 2008 Stanley Anthony Joran 7:27 PM M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4444 Fenor Road Baltimore Baltimore tf Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 214-14-3293 1921 Director 87 Jan 30, Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-f show with Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√∑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4444 Fenor Road 21227 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. XYes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by If Yes, Give Year or Dates: *41–45 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4 or 5+) 0 6 carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Frank Joran Helen Agnes Bunk ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellen Joran/spouse Helen 4444 Fenor Road Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signalute of Funeral Services State Anatomy Board 655 W. Baltimore Street rector nevi Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) YOUARDOL **Physician** /Medical Due to (or as a conse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): 2 Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit MZENSIUV that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 TYes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Chack only one) and manner stated. ŝ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who co impleted cause of death (Item 23a) (Type) Print) APOLIS 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 8 2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 2208 30. 8:45 **Physician** JOAN RITA KALTENBACH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Center Saint Joseph Medical Months Davs Hours Min. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year) **Funeral** Months Days 1 - M XX 213-16-5442 Jan.14,1921 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Timonium within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2525 Pot Spring Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 💥 No WHITE Specify: Specify: ģ 3 Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. 7 is marked other than ' than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hy 17. Father's Name (First, Middle, Last) Joseph Lyman Anderson Sr Mary Adelaide Teipe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 321 East Maple Road Linthicum, Christopher I Kaltenbach Son Maryland 21090 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Grdns 9/4/08 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility to ell-Wiele eld Funeral Home Inc onature of Funer Se e icense 6500 York Road Baltimore, Maryland 21212 Jennis X 14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METABOLIC ACIDOSIS resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed for use as the burial-transit and Due to (or as a consequence of) Box 68760 physician death certificate be Physician/Medical ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Year Month 5 Other (specify) 1∐Yes 2∭XNo P.0. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform his certificate h I director, page 2 No 2 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day, Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my online, death occurred at the time, date and place. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

TOGINDER

31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE, TOWSON, MARYLAND 21204 M.D. MEHTA 32. Registrar's Signature

lelle min

7601

D 41410

SeftenBER 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per State of Marylands // Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician 2008 12:38 IRIS DEAN KEIRN September 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Towson Center 8. Date of Birth 9. Birthplace (State or Fore Month, Day Year) 9. Birthplace (State or Fore Equation) West Virginia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Min. Months Hours 235-40-5883 83 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiliar must be rectified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√No Directo Maryland Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21093 U.S.A. 1914 Knollton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married land 21215-0036 1 ☐ Yes 2/CXNo Specify: δ XXWidowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hymes David Cecil Norma Dean ပ Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ronald Keirn 3513 Parkfalls Drive Baltimore, Maryland 21236 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-8-08 Baltimore, Maryland Green Mount Crematory 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Massive Schemic 11days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ☑No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar

State

29b. Signature and title of certifier

esha 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08

2008

32. Registrar's Signature

Samod

6701 N. Charles St. Suite 4890 Towsom, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ner land 25 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltruore Johns Holkins Care Conte Baltmare MI Dayvew 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb 22, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∏** M 2□ F Days Hours Min. 72 1936 Maryland Director 215-30-9978 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Center Place #602 21222 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2□No If Yes, Give Year or Dates: 55-5 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **'**55**-**57 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) drummer entertainment injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Kneeland Elizabeth Mahon ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traignes. Evelyn Elizabeth/sister 3457 McShane Way Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify) in state 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street icensee wade Baltimore, MD 21201 a. Part1. Enter the dise rie, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failur. List only one cause on each line. Immediate Couse (Final disease or condition resulting in death) esoplateal **Physician** Pretastatic conces months /Medical Due to (or as a consequence of): Examiner Physician/Medical Examiner Division or Vital Records, P.O. Box 68760,

law requires that the death certificate be executed burial-tran physician s been signed by i should be detach within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Completed by

Medical Certification: To Be

| Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Other 9 ☐ Unknown | ic pregnancy r (specify) | | 23d. Date of delivery Month Day Year | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Close Chetroctive Polymency Disease 1 Yes 2 No 3 Frobably 4 Unknown | | | | | | | | | |
| | <u> </u> | | 24a. Was an autopsy performed? | | | | | | | |
| 25. Was case referred to medical examiner? | | 26. Place of Dea | th (Check only one) | | | | | | | |
| 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ | DOA Other: 4 Nursing H | lome 5 Residence | 6 ☐Other (Specify) | | | | | | |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in | | | | | | | |
| 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investigated and manner stated. | red at the time, date and place ation, in my opinion, death occu | e, and due to the cause urred at the time, date a | e(s) and manner as stated. and place, and due to the cause(s) | | | | | | |
| 29b. Signature and title of certifier LISU BOULT | THO | 29c. License number D 57768 | 29d. E Av | Date signed (Month, Day, Year) | | | | | | |

3. Time of Death

3:20 A M

1 ☐ Yes 2☐ No

Approximate Interval Between Onset and Death

Registrar DHMH 17 Rev 1/2001

State

n who completed cause of death (Item 23a) (Type, Print) VV Lew 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 0545 Doris E. Ketcham 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PENINGULA EGGIONAT, MEDICAT wicomico If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 F Director 214-20-5654 Jan 6, 1927 Maryland Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 ☐Yes 2√☐ No Director Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Maple Hill Street #204 21863 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. ģ 3 Widowed 4 Divorced Completed unk unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Robbins Elizabeth Hettche ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl
Department of Health an
Important: If Item 27 is n
any Injury or other traun 100 E. Carroll Street Salisbury, MD Penninsula Regional Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in State Ronald S. Walt State Anatomy aboard 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or or dition resulting in death) **Physician** uronic /Medical Due to (or as a consequence of): Examiner enc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (of as a consequence of) requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 mortis? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 mor Day 5 Other (specify) P.0. ed by the a detached f 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 autopsy The performe 1 □ Yes 2 No or Attending Physician; 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation iours after death, neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 M Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Pipedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Sign

person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ye ar 2018 september /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Yea 8. Date of Birth (Month, Day, Sept. 24 Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) **Funeral** Days Hours Min Year) 220 - 36 - 96 18 Usual Residence of Decedent 1 M 2 □ F Yrs Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Examination and injury or other traumatic event, I'm Marical Examination and once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director a MOTE 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. δ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ommerci 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) (ungwier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Mem. Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses meral Home Joseph Ave. Balto. Md. WINORTH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) (1) € (C) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

been signed by the should be detached s certificate has be irector, page 2 sl within 24 hours after death

To the Funeral Director:
completely filled in by the f

Medical Certification: To

29a. Certifier

State

Registrar

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print) HATURS wn 6201

31. Date filed (Month, Day, Year)

(Check only one)

32 Registrar's Signature

SEP 0 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1 - State Registrar 28663 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year A^{M} August 30, 2008 Harry William Layne, Jr. 9:30 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 8510 Saint Andrews Road Chesapeake Beach Calvert 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Year) Months Days Hours 1X M 2 □ F Yrs. 234-80-9845 58 1950 Feb. 9, West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20732 8510 Saint Andrews Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 9 / 1 / 69 1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🖾 No Specify. 9/1/90 Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic U.S.P.S. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Harry William Layne, Sr. Charmaine Marie Hulbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20732 Meta J. Layne (Spouse) 8510 St. Andrews Rd., Chesapeake Beach, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/25/08 Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Highlawn Chapel 21. Signature of Fureral Service Lice. 1435 East Main St., Oak Hill, WV 25901 Approximate Interval Between Onset and Death metastatic Pancientre Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of)

Physician /Medical **Examiner**

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

Physician

/Medical

10a. State

Examiner

Funeral

Director

show

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be ဂ

th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at

Examine rsician and burial-transi physician Physician/Medical attending use for cate has been signed by the page 2 should be detached ð Completed this certificate completely filled in by the funeral director, Be Certification: To s after death.

al Director: After the

the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 🖟 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \textbf{X} Residence 6 \subseteq Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 🕅 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

24 hours a

within 2 To the I

State Registrar

Medical

10845 Town Center BIVD# 203 32. Registrar's Signature 31. Date filed (Month, Day, Year)

SEP 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 5075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner timore onesis dal 8. Date of Birth (Month, Day, Apr 18, ial Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F 1958 Mary land Apr 219-78-8592 50 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21204 7 Cuyler Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) none disabled unk unk Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, <u>11</u> <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Langston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12156 Eastern Avenue Box M Chase, MD 21027 Randy Lindamood/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5. XI Other (Specify) 4 Donation 21. Signature of Funeral Serving Ronal d 22. Name and Address of Facility S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ans Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, an each line. 23a. Part Enter the disea , or complication shock in heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed After this certificate 1∐ Yes 20 NO spital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural withing 4 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29b. Signature and

State Registrar 30. Name and add

31. Date filed (Month, Day,

Year)

2008

SEP 08

MPH 9109 Liberty

use of death (Item 23a)

egistrar's Signature

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours a

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AM.

HOSPITAL OF BALTIMORE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month. Dav. Year) RES- 000 August 27 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIROTRA MOHIT MA SINAI

31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 8 2008

Medical

State

Registrar

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28566 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day -Mont **Physician** 21401 COLLEEN ANNE McCARDELL 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE TOWSON GILCHRIST CENTER if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 💢 F 10/01/1946 MARYLAND 219-42-7217 61 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 □Yes 2 No MD BALTIMORE PARKTON Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 21120 USA 18301 PRETTYBOY DAM RD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Black, White, etc. 1 ☐ Yes 2 No if Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATOR Elementary/Secondary (0-12) 12YRS College (1-4or 5+) than CHIMES INC. ADMINISTRATOR Hygiene 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be ANNE VICTOR PATRICK W. NOONAN SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 18301 PRETTYBOY DAM RD. PARKTON, MD 21120. permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra once. DAVID W. McCARDELL JR(HUSB) Health a Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State DULANY VALLEY 09/08/2008 TIMONIUM, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fungral Service Lie hsee HENRY 16924 W. JENKINS & SONS YORK RD MONKTON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final POVING **Physician** disease or condition resulting in death) /Medical Due to (or as a consumence of) **Examiner** Sequentially list conditions, if any, leading to immediate clause Cluses or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the SBS IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Sther (Specify) Hospike 2 ER/Outpatient 2 No 3 DOA 1 🗌 Yes 1 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation n 24 hours after death.
the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 **RILEY 6701** CHARLES ST. TOWSON, MD. 32. Registral Signature State Registrar

08-06740 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Winifred Mulcare State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 3, 2008 Medical Examiner Winifred Mulcare 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Gwynn Oak 1121 St. Agnes Lane #306 If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Foreign Months Days Hours Min Director 1 M ^{2}X 125-44-7600 80 04 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 23a or 28a-f show notified at once, NA Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f ebox Director 10e. Street and Number 10f. Zin Code 1123 St. Agnes Lane Apt 306 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? White etc. 1 X Never Married 2 Marrier 2X No Yes If Yes, Give Year 3 Widowed Specify: Divorced 1 Yes 2 X No specify: ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) |12th grade 4yrs Registered Nurse 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Alfred Mulcare Ann Erye 19a. Informant's Name/Relationship (Type, Print) If item 27 i Jennifer Bramble-Niece 8206 Elora Lane, Brandywine, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date timore, crematory or other place) 1X Burial 2 Cremation 3 Removal from State portant: | ury or oth King Memorial Park 9/11/08 Donation 5 Other Specify 22. Name and Address of Facility
March F/H West
4300 Wabash Ave 21_Signature of Funeral Service License 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** failure. List only one cause on each line. /Medical a Blunt Force Head Trauma Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical UNPENDED AMENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month 2 past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown o contributing to death but not resulting in the underlying cause given in Part I. δ. σ. Completed 24a. Was an autopsy has performed? death? certificate h ✔ Yes 2 1 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ DOA Nursing Home 5 this Inpatient 2 ER/Outpatient 3 1 🗸 Yes No

Baltimore County 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Indies 10d. Inside City Limits Y Yes 2 10g. Citizen of What Country 14. Race - American Indian, Black, Black 16b. Kind of Business/Industry State of New York 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20613 20c. Location - City or Town, State Woodlawn, Md 21215 Approximate Interval Between Onset and Death Hospital or Attending Physician: The law requires that the death certificate be executed Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of No Residence 6 V Other: Scene ٥ 28a. Date of Injury (Month, Day, Year) Sep 2, 2008 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: Subject fell 0730 hrs Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Pending Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1121 St. Agnes Lane #306, Gwynn Oak, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. September 4, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. 31. Date filed (Month, Day, Year 32. Registrar's Signature U Registrar

0925 hrs

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06732 State of Maryland / Department of Health and Mental Hygiene Kevin Magwood 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 3, 2008 0045 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death Baltimore Sinai Hospital 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Min. Months Davs Hours Director 1 × M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show more with the Maryland Funeral Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. death 7 1 Never Married 2 Yes Yes 2 X No specify: hours after 4 Divorced If Yes, Give Year ð 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be State, Zip Cod ٩ 19a, Informant's Name/Relationship (Type, Prin.) 19b. Mailing Address (Street and Nur or Rural Route Number, City or Town mothe Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 2 Cremation 3 crematory or other place) Burial Other Specify Donation 5 anature of Funeral Service Licens. 22. Name and Address of Fa Part I. Enter the disease, or complications the failure. List only one cause on each line. Approximate Interval caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Medical Death Complications of chronic ethanolism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death lettificate be executed. 24 hours after death events resulting in death) Last and Physician/Medical 23a,27,perME, g883 9/11/08 TT XUNPENDED signed by the atter ding physician be detached for u.e as the burial Division of Vital Records, P.O. Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 / Inpatient 2 Other: Other ER/Outpatient DOA Nursing Home 5 Residence 6 After this 1 V Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Funeral Director: stely filled in by the To the 1

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OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifier

Ana Rubio MD.

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) September 2008 **Physician** 3:00 A Ethel MILLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Adelphi Prince Georges Heartland Healthcare Center 8. Date of Birth (Month, Day, Dec. 2, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F Pennsylvania T916 91 Director 160-05-3720 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f show must be notified at 1**y**□Yes 2□No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code with United States 20852 6111 Montrose Road death \ Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or items traumatic event, the Medical Examiner m Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married white 1 ☐ Yes 2X No Saltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Secretarial Typist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Friedman Harry Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4856 Sweetbirch Road, Rockville, MD 20853 19a. Informant's Name/Relationship (Type. Print) Gail Bigio, Niece Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/05/08 Collingdale, PA Mt. Lebanon Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Fundal Service Deensee 254 Carroll St., NW, Washington, DC shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Failure **Physician** /Medical Due to (or as a consequence of) Examiner Cardiac Arrhythmia Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner he law requires that the death certificate be executed Anemia burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown t een signed besta 23e. Did tobacco use contribute to the cause of death? Part I). Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 ☐ Yes 2 □ No Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier aryd. MD MD 52855 September 4, 2008 ., 7207 Hanover Parkway #B, Greenbelt, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Chandra Korapati, M.D., 31. Date filed (Month, Day, Year) 8 2008

e Rin maras

Physician

Examiner

Funeral

Director

/Medical

1. Decedent's Name (First, Middle, Last)

10c. City, Town or Location show 10a. State Director orrant: if item 27 is marked other than "natural", or items 23a or 28a-f si injury or other traumatic event, if a Medical Examination that be rediffed Baltimore Co. Rosedale MD 10f. Zip Code 10e. Street and Number with 21237 2022 Kelbourne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", any injury or other traumatic event, if a Medical Exagnes. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9 N/A <u>Homemaker</u> 17. Father's Name (First, Middle, Last) Be Edward Henninger 19a. Informant's Name/Relationship (Type. Print) Frank Marasa - Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview Crematory 9-4-2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Die to (or as a consequence of) Infarction **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No P.O. 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, 2 Hypertension, Hyperalycemia cate has been si page 2 should b Completed ercholesterole mia 24a. Was an 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ∐Yes 2 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this. 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Injury 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier am, cell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR 9000 R. WILLES OR STUGIT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Day 1807 O M 9 2008 Catherine H. Marasa 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore FRANKLIN SQUARE HOSPITAL Rosedale Center 8. Date of Birth (Month, Day, Year) 2 - 15 - 1934 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2**X** F 218-28-3916 Maryland Usual Residence of Decedent 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Home 18. Mother's Name (First, Middle, Maiden Surname) Irene Hommerbocker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2022 Kelbourne Rd. Rosedale, MD 21237 20c. Location - City or Town, State |Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 21222 Onset and Death 72 has 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 00/01/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

Year

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2008 Saby Gir 800 N /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner BAIMMOVE Ralthore MWWZ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖾 F Yrs. MÍ 2008 Director infant Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiene. Intropretant: If them 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be reserved. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1√ Yes 2 No Baltimore Funeral Director MD 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number USA 21230 1354 Cleveland Street 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 PNever Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 【 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Miles Sheena ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) cleveland St. Baltimore MD 21230 Sheena Miles/mother 1354 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Prematurity **Euriner** Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use es the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) I get Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 XNo Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1U Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2⊠ No Medicai Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 1 Natural 5 Pending s efter deam. 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrer's Signatur

State

Registrar

31. Dete filed (Month, Day,

SEP

2008

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28672 Certificate of Death Reg. No. 3. Time of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Lest) Month Dey Year Physician Babi GIVI MIKES 800 a 8 22 2008 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Caltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1 M 2 KF Yrs 8 Director 22 infant Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mentel Hygiene. Int: If them 27 is marked other than "naturel", or items 23s or 28s-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits t¶ Yes 2□No **Funeral Director** MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1354 Cleveland Street 21230 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Maritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0020 Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Lest) unk Be Sheena Mikes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cleveland St. Baltimore mo Sheena Miles/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Depertment of Himportant: If Ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) 21. Signature Ronal Collicenses de, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 and 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Prematurity

Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner use es the buriel-trensit or Attending Physicism: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Due to for as a consequence of. Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 21 No 1 ☐ Yes 2 ☐ No 1 LI Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 1 Nnpatient 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending after death.

I Director: Af 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C the Hospital 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated (Check only Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end mancer stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACCA 32. Rasstrer's Signeture 31. Date filed (Month, Dey, Year) State SEP 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, perMD, g884 10/6/08 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 6:15 P.^M September 2, 2008 Ruth M. Norris 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Catonsville 1032 Marksworth Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Maryland 1 □ M 2 🗓 F 212-05-2478 Nov. 16, 1918 89 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 1032 Marksworth Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐Yes 2X No Specify: 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Louise Schlaich Edward Bernard Piquett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1032 Marksworth Road; Catonsville, MD 21228 Elaine Mazza Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Loudon Park Cemetery 9/5/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License Approximate Interval Between Onset and Death ay 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cross on each line. not enter the mode of dying, such as cardiac or respiratory arrest,
Ascending aortic dissection caused by Immediate Cause (Final disease or condition resulting in death) aneurysm Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Manner of Death 28a. Date of Injury Injury (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed and burial-trai Division of Vital Records, P.O. Box 68760, the attending physician the for use a detached funeral director, page 2 should be has certificate this After 1

Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redtified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be Certification: To

within 24 hours after death.

To the Funeral Director: A filled in by the Hospital completely

> State Registrar

Medical

ure and title of ce 29b MD Name and address of perso

2008

6 □ Could not be

SEP 0 8

determined

3 Suicide

29a Certifier

4 Homicide

eck only

31. Date filed (Month, Day, Year)

29c. License number D001941

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

NE

Certifying Physician. To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original data.

29q. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

wath (Item 23a) (Type, Print) 00 11,

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month C **Physician** ZOUY NELSON /Medical 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) Examiner Memorial ttosp: more 8. Date of Birth (Month, Day, Year) **6.25.1934** Birthplace (State or Foreign Country) Under 24 Hrs 5. Social Security Number 6. Sex **Funeral** Min. Months Days 1□M 2**Y**F 46-595 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or items 23a or 28a-f show adical Examiner must be notified at Baltimore 1 Syes 2 No Director 10f. Zip Code 10g. Citizen of What Country? by Funeral and 2 should be filed within 72 hours after death ealth and Mental Hygiene. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use refleed) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) @ellege (1-4or 5+) vears or other traumatic event, Be ္ရ 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trat Baltimore Pages 1 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Licensee tona 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 minutes **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner he law requires that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760, physician BACTEBEMITA Physician/Medical the attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 morms? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificale 1∏ Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. I Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an

State Registrar 30. Name and address of person who completed cau

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2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

UNION MEMORIAL HOSPITAL

se of death (Item 23a) (Type, Print)

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 28675 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month September 5, 2008 **Physician** LOIS ETHEL BILSTEN ORESCHNICK 8:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRESBYTERIAN HOME OF MARYLAND, INC. Baltimore County Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Min. | Dec 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 257F 1919 470-12-1570 88 Minnesota Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Baltimore County Directo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mantal Hygiene. Importent: if Itam 27 is marked other than "natural", or Iteme 23a any njury or other traumatic event, the Medical 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) Kindergarten Teacher Christian Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Bilsten Dorothy Andersen ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Presbyterian Home of Maryland, Inc.
400 Georgia Court, Towson, M. 21204
20b. Place of Disposition (Name of cometery, crematory or other place) Sue Shea (Administrator) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/9/2008 Glen Haven Mem Pk Glen Burnie, Maryland 21. Signayly of Fungial Service Libersee MITCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) meumana **Physician** dams /Medical Examiner Esquentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical USB as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending М 1 □ Yes 2 □ No investigation 2 Accident in by the 6 Could not be determined 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d, Date signed (Month, Day, Year, 29b. Signature and little of certifie 1)30433 Sept 05, 2008 Ballimore Ma 21204 who completed cause of c ath (I 20 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 4,2008 September 3:28a Ortiz Anthony /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore City N/A5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours 6-22-1952 Director 212-60-8167 56 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medinal Examiner must be notified at Director 1 XYes 2 □ No N/A MD Baltimore 10g. Citizen of What Country? Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 2, once. 10e. Street and Number 10f. Zip Code 3915 Frankford 21234 USA Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 2 🔀 No 1 Never Married 2 Married 1 X Yes 2 No Specify ģ 3 ☐ Widowed 4 Noivorced Puerto Rican Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Efain Ortiz Rivera Eloisa Castillo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rebecca Ortiz - Daughter 232 Rockdale Ave. York, PA17403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9-8-08 Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): physician Physician/Medical the ası attending IF FEMALE nse s 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Miknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1∐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2,10 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Ye SFP 0 8

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Name and address of person who completed gause of death (Item 23a) (Type, Print)

8 2008

gm woods Road, Suite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U U 8 28671 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:20 /Medical 4b. City. Town, or Location of Death 4c. County of Death cility Name (If not institution, give street and number) Examiner he SaltiMore If Under 1 Year | If Under 24 Hrs. Year) **Funeral** Days 1 □ M 2 X F Months Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinator, ust by notified at once. 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ rene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3916 Humphrey Gwynn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Battimore, 4 ☐ Donation 5 ☐ Other (Specify) lount Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Balto., Md. 21229 Approximate Interval Between Ouset and Peath Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of de ? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 V Unknown 4b. Were autopsy findings available prior to completion of cause of death?

1 □/res 2 □ No 24a. Was an director, page 2: autopsy Vital 1 □ Yes 2 🗾 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 6 Other (Specify) ð 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manni Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: filled in by the Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day.

Registrar

State

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6:30pm

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who completed cause of death

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06694 State of Maryland / Department of Health and Mental Hygiene 2008 28678 Larry Patterson Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day September 1, 2008 Physician/ 0955 hrs Patterson Medical Examiner Larry Allen c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia 4951 Columbia Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country' **Funeral** Min. Months Days Hours West Virginia July 17, 1943 Directo 1 X M 2 65 Yrs 235-66-9275 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Alpharetta 28a-f show GA Fulton 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number 23a or 28a-notified at USA 30004 115 Uplands Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No with 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married Never Married Yes 2 X No White Specify: f Yes, Give Year 2 X No specify Yes Divorced permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Mencal Examiner <u>გ</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Air Defense College (1-4 or 5+) Elementary/Secondary (0-12) Contractor MD 21215-0036 Computer Consultant 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Erma Aldine Fox Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Uplands Court
Alpharetta, GA 30004 Marvin R. Patterson 19a. Informant's Name/Relationship (Type, Print) Barbara Patterson/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place)
Wallace Memorial Cremation 3 Removal from State X Burial 2 9/6/08 Clintonville, WV Cemeterv Donation 5 Other Specify Wallace & Wallace 22. Name and Address of Facility ignature of Funeral Service Utens Rainelle, WV Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death 'Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician for use as the burial 23d Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FFMALE: Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 V Unknown ģ Chronic Ethanolism Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? this certificate has performed? 1 V Yes No Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical Be examiner? Other_z Residence 6 V Other: Scene Nursing Home 5 Hospital: DOA ER/Outpatient 3 Inpatient 2 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: n 24 hours after con-1 V Natural Yes 2 No Pendina Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

32. Registrar's Signat

A COM

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 2, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 5, **Physician** Barbara PASTOR 2008 1:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9618 Hillridge Drive Kensington Montgomery 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Davs 1 □ M 2 🛚 F 60 199-38-8215 Director 9. 1948 Pennsvlvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 3a or 28a-f show t be notified at 1 Y Yes 2 □ No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20852 1620 E. Jefferson Street #131 "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21√2 No Specify. ģ Specify: white 3 ☐ Widowed 4 ₺ Divorced Completed er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education other 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Selma Danan Benjamin Berman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 19618 Hillridge Drive, Kensington, MD 20895 Heather Moran, Daughter Health tem 27 i 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 09/05/08 Alexandria, VA 21. Signature of Funeral Service Licensee Törkhinsky Hebriew Funeral Home <u>254 Carroll St., NW, Washington, DC</u> 23a. Part1. Each the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) 5 Months **Physician** Acute Non-lymphocytic Leukemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transi Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has t autopsy performed? Yes 2 XNo certificate 25. Was case referred to medical examiner? funeral director, Be Daug ter 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 NOther (Specify) Home 27. Manner of Deat 1 ☑ Watural 28a. Date of Injury 28b. Time of After ! 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending after death.

Director: A filled in by within 24 hours at To the Funeral C completely filled i Hospital

State Registrar

Medical

6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Ram S. Trehan, M.D., 1400 Forest Glen Road #435, Silver Spring, MD 20910

31. Date filed (Month, Day, Year) SEP 08

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

D 33224

29d. Date signed (Month, Day, Year)

September 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State Registrar | State | of Marylar | • | artmen rtificat | | | ind Me | | jiene _{eg. No.} 2 | 008 | 28680 |
|-------------------|--|----------------|---|---|---|------------------------------------|--------------------------------------|--------------------------|-----------------------------|--------------------------|---------------------------------|-------------------------------|-----------------------------------|---|
| | | | 1. Decedent's Name (First, Mide | dle, Last) | | | | | | | 2. Date of Dea | | V | 3. Time of Death |
| и | Physicia | | Garnere Reduidhd | | | | | | | | Month August | 22, 2 | 008 | 11:55 PM ^M |
| | /Medic Examin | | 4a. Facility Name (If not instituti | on, give street and r | number) | - | 4b. City, | Town, or | Location of | f Death | 4c. County ol Death | | | th |
| | | | 10805 Greens | boro Road | | | | Den | ton | | | Car | oline | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birthday) | | 1 Year | If Under 2 | 24 Hrs. | 8. Date of Birth (Month, Day | (Vear) | 9. Birt | hplace (State or Foreign |
| | Director | | 219-30-9812 | 1□M 2∏F | 7 | 2 Yrs. | Months | Days | Hours | J. | Ian 25, | 1936 | | yland |
| | D . | | Usual Residence of Decedent | | | | | | | | | | | |
| | how | _ | 10a. State 10b. Coun | ty | 10c. Ci | ity, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | e Wa | 5 | MD Car | oline | | Den | ton | | | | | | | 1 ☐ Yes 2 € No |
| | 라 다 or 28 | Director | 10e. Street and Number | | | | 10f. Zig | | | | 1 | - | of What Co | ountry? |
| | 23a | | 10805 Greensb | oro Road | | | | | 21629 | | | | USA | |
| | ams ams | In e | 11. Marital Status | | ecedent Ever in U Forces? | J.S. 13. | Was Dece If Yes, spe | dent of H | ispanic Orig in, Mexican | gin? (Spec , Puerto R | rify Yes or No- lican, etc.) | 14. | Race - Ame Black, Whit | erican Indian, e, etc. |
| 36 | or it | by Funerai | 1 ☐ Never Married 2 🔀 Ma | If Yes. | s 2∭∑No Give | | 1 🗆 Yes | 2 X No | Specify: | | | Sp | ecity: wh | ite |
| Ö | urai', | D D | 3 ☐ Widowed 4 ☐ Divorce | | Dates: | | | | | | | | | |
| 21215-0036 | within 72 hours after death with the Maryland ene. Than "natural", or itams 23a or 28a-f ehow he Madical Examiner is ust be notified at | Completed | 15. Decede (Specify only high | ent's Education lest grade complete | d) | 16a. Dece (Give | dent's Usu kind of wo DO NOT u | rk done d | during most | of working | g | 16b. Kind | of Business | rindustry |
| 2 | Mithir Than | Ē | Elementary/Secondary (0-12) |) College | (1-4or 5+) | | st fo | | • | | | f | ood i | ndustry |
| N | filed Hygie other | | 12 17. Father's Name (First, Middle | | | | ISC IC | Jou C | | r's Name | (First, Middle, | | - | nadsery |
| an | ntal h | Be | Robert Samuel | | | | | | | | a Anna | | , | |
| Ž | 2 should and Men is marke aumatic | ၉ | 19a. Informant's Name/Relation | | | 10b Maili | na Addrasi | (Street | | | Route Number | | - | Zin Code) |
| Maryland | | | Charles Redmon | | | | | | | | ad Dent | | | 629 |
| | 1 and Health em 27 ther tr | 100 | 20a. Method of Disposition | -, -1 | 20b. | Place of Dispo | | | 1 | Da | | | | Town, State |
| Baltimore, | Pages nert of I int: if it iry or o | | 1 ☐ Burial 2 ☐ Cremation | | | cemetery, crei | matory or o | other plac | (e) | | | | , | |
| tir | i. Parturant | | 4 ☑ Donation 5 ☐ Other | | / | | • Ne | - 444 44 | 4 FUE | . 1 | CEE II | D - 14 | - | Ctroot |
| Bal | permit. Departr Imports any inju | | 21. significe of Funeral Service Ronal A | S. Wad, | Pirecto: | | | | _ | | | . Bal | Limore | Street |
| | 22244 | | my | 1600 | | 1 1 | Balti | more | , FID | 2120 | 1 | | - | Approximate |
| | | | 23a. Part1. Enter the disease/ shock or heart failure. Li | ist only one cause of | n each line. | ith. Do not en | ter the mod | e oi ayın | g, such as | cardiac or | respiratory arr | est, | | Interval Between Onset and Death |
| 7 | Physician | | Immediate Cause (Final disease or condition resulting in death) | _a ~ | NIAhe | eral | 1950 | Ula | 1 | 150 | ase | | | VEGAS |
| | /Medical Examiner | | Testiting in deatily | Due | to (or all a conse | quence ol): | | | | | | | | |
| | | _ | Sequentially list conditions, | b | to (or as a conse | augros of): | | | | | | | | |
| | ed str | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | - € | to (or as a conse | querice or, | | | | | | | | |
| | and and I-trar | xan | that initiated events resulting in death) Last | c | to (or as a conse | quence of): | | | | | | | | |
| 8760, | The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit | alE | | | (| , | | | | | | | | |
| 87 | phys the | dical | | d | | | | | | | | | | |
| 9 x | ding | /Me | IF FEMALE: | 23c If yes | outcome of pregn | ancy | | | | | | 22- | I. Date of de | livor |
| Вох | atten for u | ian | 23b. Was decedent pregnant in the past 12 months? | 1□Liv | e birth 2 Fet | al death 3 | ☐Ectopic p☐Other (s | | | | | 230 | Month | Day Year |
| | the de | Physician/Me | 1 ☐ Yes 2 12 No 9 ☐ Unknown | a⊟n | | dealli 5L | □ Ottiet (2) | Decity) | | | | | | |
| P.0 | that i | | Part II. Other significant condi | itions contributing to | death but not re | sulting in the u | ınderivina | cause div | en in Part I. | | 23e. Did to | bacco use | contribute le | o the cause of death? |
| Records, | signed to | Completed by | Atrio | Fif | Brills | tir | 211 | | | | 1 D Y | es 2□N | No 3 | robably 4 Unknown |
| Ö | w require been si should | ete | | | No 1 1 1 1 1 1 1 1 1 1 | | | | | | 04 146 | | | P. d |
| 3ec | e faw has l | gu | | | - | | | | | | 24a. Was a autop perfor | sy | 24b. Were a prior to death? | utopsy lindings available completion of cause of |
| _ | cete | | | | | | | | | | | 2 2 No | 1 🗆 Yes | 2 □ No |
| Division of Vital | ician certifi ector | Be | 25. Was case referred to medic examiner? | Hospital: | | | | 1.0% | | of Death | (Check only or | ne) | | |
| of | shys this al dir | 2 | 1 Yes 2 No | 1 | | ER/Outpatie | | | 4 140 | | ne 5 Resid | | Other (Spe | ecify) |
| Ę | ling I | lo | 27. Manner of Death 1 ☑Natural 5 ☐ Pend | | te of Injury lonth, Day Year) | 28b. Time o Injury | | 28c. Injur Wor | | | 8d. Describe h | ow injury o | ccurred | |
| Sic | tend Jeath tor: , | Certification: | 2 Accident Inves | stigation | | | M | | Yes 2 □ I | | Ol Leasting (C | Stenat and A | /washaway Or O | lucal Courts Museum |
| Ξ | or At | Ħ | | mined 288. Pla | ace of Injury - At I ilding, etc. <i>(Spec</i> | nome, larm, st ify) | reet, lactor | y, office | | 2 | City or Tow | n, State) | Number or H | ural Route Number, |
| _ | pitai ours e orai l | | 20a Cartifica | vio a Physician 7 | the heat of | awled-s t- | lh a · · | 1 - 1 - 1 | | el el : : | and alice to the | -4.5 | | |
| | To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2 | Medicai | 29a. Certifier 1 Certifi (Check only 2 Medic | ying Physician: To al Examiner: On the | the best of my kn basis of examin anner stated. | iowiedge, deal lation and/or in | in occurred ivestigation | at the tir n, in my o | ne, date an pinion, dea | th occurre | nd at the time, o | ause(s) and pl | ace, and du | s stated. e to the cause(s) |
| | ithin : | Mec | 29b. Signature and title of certr | | unior stateu. | | 29 | c. Licens | e number | | | 29d. Date s | igned (Mon | th, Day, Year) |
| | £ ₹ 8 | |) D | X | 0 | 117 | 7 | | 217 | 7 | / | 2-5 | 17- | C-86 |
| | | | Jane. | - John | LL J | . 191 | | J. | 11 - | 1/6 | | 0 | -/ | |
| | | | 30. Name and address of person | on who completed ca | ause of death (Ite | m 23a) (Type, | Print) | C+ | - N | 0,7 | -0.43 | 14 | 100 | 1179 |
| | C. | | 31. Date filed (Month, Day, Yea | ar) | . Registrar's Sig | lature - | . 80 8 | DC | | | | 16 | | 6 |
| | Sta Registi | | orn 0.8 | 10°-a | 100 10 | CHOR | -36 | | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** STROHMER ADELE 3:20 P M September 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Joseph Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 102 Feb. 10, 1906 Director 220-48-8326 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Crownsville 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code a or "natural", or items 23a USA 625 Cedarwood Lane Funeral 21032 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Telephone Information Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Rosendale Rita Filippino မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Strohmer 625 Cedarwood Lane; Crownsville, MD 21032 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 1 Burial 2 □ Cremation 3 □ Removal from State 9-9-2008 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lic 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final MYOCARDIAL **Physician** INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> HYPERTENGEON 1 Yes 2 No 3 Probably 4 Unknown Completed NEUROLLY MEDISTED SYNCORE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform STENOSES ADRITOC 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMAN & BERLESS NO. SEPTEMBER 5, LOOG FREDERICK ROM, SUITE IS, BACTIMBRE, MO- JIX 29 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#4c, perPHYS., G883, 9710708, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5,2008 Month SEPT. ALBINA TEOFILIA SWISTON 2:00 a M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. Cou unty of Death Baltimore 7221 CONLEY STREET BALTIMORE 8. Date of Birth (Month, Day, Year) FEB. 22,1923 6. Sex If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 85 FEB. MARYLAND 215-18-7385 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 N. KENWOOD AVENUE 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARION NASAZEWSKI MARY OZAZEWSKA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY JANE REINTZELL/DAUGHTER 7221 CONLEY STREET, BALTIMORE, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLY ROSARY CEMETERY 9/9/08 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee and Address of Facility
Y & ZEILER INC. & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE VASCULAR DEMENTA disease or condition resulting in death) Due to (or as a consequence of): OLD CUA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes payoffers Residence 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify BLT, MD 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Examiner burial-trai nding physician ause as the burial death certificate be for P.0. signed by i Division or Vital Records, page 2 s Physician: funeral After or Attending

death after death Director: the filled in by To the Hospital within 24 hours a To the Funeral I completely

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

"natural", or

marked other

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

with the Maryland

death v

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyol Important: If them 2.7 is marked any Injury or other them.

Physician

/Medical

Maryland 21215-0036

Examiner Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Certification: To 27. Manner of Death 2 Accident 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) compositioner MS SEPTEMBER 5 2008 016619

Registrar

State

MARKE.

9940 FRANKLIN

32. Registrar's Signature

SQUARE DR. NOTTINGHAM MO. 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.VERGARA-SOARES

2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? | | | | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary Stewart-Hayes August 22, 2008 11:02 AMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 90 Monroe Street #1004 Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 1, 5. Social Security Number unk 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Director 85 Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f shov Examiner must be notified at MD Director Montgomery Rockville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 90 Monroe Street #1004 20850 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, unk Black, White, etc. filed within 72 hours ofter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event gates. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOntgomery Police Dept 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Sepice Licensee Ronald S, Wade, State Anatomy Board 655 W. Baltimore Street mi 21201 Baltimore, MD 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): CITY LINGSC /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral dir 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fund completely f (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 2121 metical 1201 Pr AL WO DENE V5 27 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECKER, mo ONE 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

Amend #8, per Fit G883 9/15/08 TT State of Maryland / Department of Health and Mental Hygiene Cortificate of Death 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 5:00 QM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 □ F Months Hours Min Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country USA death 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2**X**No ģ 3 Widowed 4 Divorced tollic Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ 4, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 pe Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery signed by the atter I be detached for u 3 Ectopic pregnancy Day Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has certificate 2 No Division of Vital 2 **X** No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2**X** No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 143725 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIO MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 08 Registrar 2008

DHMH 17 Rev 1/2001

5:00

2008

SEPTEMBER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:12 P M 2008 Gloria Maxine Valaer August 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly

The state of the stat Prince George's Hospital Prince George's Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 💢 F Director 577-70-6007 57 20, 1950 Washington, Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show or than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 🗓 No Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4714 Nicholson Street 20737 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othy any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Leonard Laura Frances Leonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Valaer (Spouse) 4714 Nicholson St., Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation Metropolitan Crematory 9-4-08 Alexandria, VA 5 ☐ Other (Specify) 22. Name and Address of Facility
Royston Funeral Home 21. Sign ture of Fineral Service Licensee enne E. Washington St., Middleburg, VA 20117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed Uncontrolled Grave's Disease sician and burial-tran Due to (or as a consequence of) physician the burial Box 68760 Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) signed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy The performed? 1 ☐ Yes 2 🖾 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation ours after death. death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D26287 August 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 7305 Baltimore Blvd., College Park, MD 20740 Michael Berard, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 08

Registrar

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| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | inoate or i | | 2. Date of Dea | ath | 00 | 3. Time of Death |
| | Physicia | | | ALSCH | I | | | Sept | Day | Year | 440 pm |
| met. | /Medic Examin | | 4a. Facility Name (If not institution, give street and number | | | 4b. City, Town, or | r Location of Death | | 4c. County | | |
| - | Xuiiiii | ŭ. | FRANKLIN SQUARE HOSPITOL | cen | TER | Rose | edale | | Ba | | none |
| | Funeral | | 5. Social Security Number 6. Sex 7.7 | Age (In yrs. la: | st birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt 2 18 7 | h Y- ŏ^e3 ()6 | 9. Birthr | place (State or Foreign htry) YLAND |
| | Director | | 218461662 1 LPM 2 F Usual Residence of Decedent | 62 | Yrs. | | | 2/10/ | 1940 | MAR | YLAND |
| | land ow | | 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | - | 1 | 0d. Inside City Limits |
| | Mary a-f sh | tor | MD BALTIMORE | | CHASE | | | | | | 1 □Yes 2 X No |
| | th the or 28; e noti | Jire | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | What Coul | ntry? |
| | be filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at | Completed by Funeral Director | 13125 SYLVAN AVENUE | | | | 220 | | USA | | |
| | er dea | nne | 11. Marital Status 12. Was Deceder Armed Forces | ? | . 13. | Was Decedent of H If Yes, specify Cuba | lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | - 14. Ra Bla | ce - Ameri ck, White, | |
| 36 | rs aft | by F | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates | 」™º ∷VIETN | 1AM | 1 □Yes 2 □ X io | Specify: | | Specia | fy: WH | ITE |
| 21215-0036 | 72 hou 'natura | ted | 15. Decedent's Education | 1 | 16a. Dece | dent's Usual Occup | ation during most of work | ing | 16b. Kind of B | Business/In | dustry |
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| | e filed within al Hygiene. other than ' vent, ine Ma | | | | | TEEL WO | 18. Mother's Nam | /First Middle | | | ETI |
| and | be fil ntal F ed otl | Be | 17. Father's Name (First, Middle, Last) HERMAN WALSCH | | | | ANGI | | RIZZO | ne) | |
| Maryland | should be nd Menta marked imatic ev | မ | 19a. Informant's Name/Relationship (Type. Print) | | 19b. Mailir | na Address (Street | and Number or Rui | | | n, State, Zij | o Code) |
| | s 1 and 2 should of Health and Mer ttem 27 is marke other traumatic | | GARY J. CAMPBELL/SIEP | SON | | • | E ROAD B | | | 212 | |
| ம | s 1 ar | 1 | 20a. Method of Disposition | 20b. Pla | | sition (Name of matory or other place | | Date | 20c. Location | - City or To | own, State |
| Ë | permit. Pages Department of I Important: If Ite any injury or o | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Star 4 ☐ Donation 5 ☐ Other (Specify) | | | REMATOR | | /08 | BALTI | MORE | , MD |
| alti | Departn Mporta Importa any inju | | 21. Signature of Fune of Service (censue | | 22 | 2. Name and Addre | ess of Facility CV | ACH/RO | SEDALE | FUN | ERAL HOME |
| _ | 9 9 E 8 9 | 1 | | | | | SACO AV | | | MD | 21237 |
| | | | 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each | ed the death. line. | Do not ent | ter the mode of dyi | ng, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| 1 | Physician | | regulting in death) | rrho | | | | | | | |
| | /Medical Examiner | | Due to (or | as a conseque | , | ALCONO | ol Abu | C 40 | | | 4 years |
| | | ē | Sequentially list conditions | as a conse que | | 1000110 | , and | , – | | | |
| J. | executed n and ial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | |
| 0 | e executed ian and ırial-transit | Exc | | as a conseque | ence of): | | | | | | |
| 68760, | The law requires that the death certificate be ate has been signed by the attending physicial bage 2 should be detached for use as the bur | Physician/Medica | d | | | | | | | | |
| 9 × | ding p | /Mec | IF FEMALE: 23c. If yes, outcome and the second seco | ne of pregnan | nev | | | | 004 D | ata of dali | |
| Вох | eath (atten for us | cian | in the past 12 months? | n 2 ☐ Fetal t at time of de | death 3 | ☐ Ectopic pregnand ☐ Other (specify) _ | су | | | ate of deliv Ionth | Day Year |
| P.0. | the d ny the iched | ysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown | | | | | | | | |
| т, П | e law requires that the de has been signed by the e 2 should be detached | y P | Part II. Other significant conditions contributing to death | but not resul | lting in the u | nderlying cause giv | en in Part I. | 23e. Did t | obacco use cor | ntribute to | the cause of death? |
| ğ | en sig | ed b | smoking | | | | | 10 | Yes 2 □ No | 3 → Pro | bably 4 🗌 Unknown |
| Division of Vital Records, | law re as be 2 sho | Completed by | | | | | | 24a. Was | psy | prior to co | opsy findings available ompletion of cause of |
| <u>۳</u> | The zate h page | Som | | | | | | perfo 1 □ Yes | rmed? | death? 1 □ Yes | 2 □ No |
| Vita | Ician; sertific ector, | Be | 25. Was case referred to medical examiner? Hospital: | | | T _{Ott} | 26. Place of Dea | | | | |
| of | Physician: r this certifica rał director, p | 2 | 1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inp. 27. Manner of Death 28a. Date of I | | ER/Outpatie 28b. Time o | III 3 LI DUA | 4 LI Nursing H | ome 5 Resi | dence 6 🗆 O | | ify) |
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| /isi | Attending r death. ector: After by the funer | fica | 3 Suicide 6 Could not be 28e. Place of | Injury - At hor | me, farm, st | reet, factory, office | | 28f. Location (| Street and Num | nber or Rui | ral Route Number, |
| á | alor s afte al Dire | Certification: To | 4 ☐ Homicide determined building, | etc. (Specify | , | | | City or To | wii, Glatej | | |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | | 29a. Certifier 1 ✓ Certifying Physician: To the besician Check only 2 ☐ Medical Examiner: On the basic | | | | | | | | |
| | the Finin 24 the F | Medical | one) and manner | stated. | | 29c. Licens | se number | | 29d. Date sign | ed (Month | . Dav. Year) |
| | 5 ¥ 5 ₽ | | 29b. Signature and little of certifier | | | | 4 | -8 | | | 6 |
| | \. | | 30. Name and address of person who completed cause | death (Item | 23a) (Tyne | Print) | 10037 | 0 | JEK I | 9 | |
| | JIX | | DR John Perkins JR | 9000 | FRA | nklin | sauare | DR | alto i | nd a | 21237 |
| | Sta | ite | 30 Name and address of person who o impleted caused by John Parkins Ja. 31. Date filed (Month, Day, Year) SEP 0 8 2008 32. Reg | strar's Signat | ure | K) | | | | | |
| | Registr | ar | SEP U 8 ZUUO | | 11/1 | | | | | | |

| | | State of Maryland | d / Depa | artment of Hea | Ith and Me | | iene 2 () eg. No. | 08 | 28687 |
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| | ¢, | Registrar 1. Decedent's Name (First, Middle, Last) | | imoute or Bet | | . Date of Dea | | | 3. Time of Death |
| Physic | | Willie | Wo | odley Jr. | | Month 08 | Day 28 2 | Year 008 | 3:40a. ^M |
| /Med Exam | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Loca | | Uo | 4c. County | | 3:40a. |
| LAdiii | iiiei | Season's Hospice | | Randa | llstown | ו | В | alti | nore |
| Funera | ī | 5. Social Security Number 6. Sex 7. Age (In yrs. I | ast birthday) | | Jnder 24 Hrs. 8 ours Min. | Date of Birth (Month, Day 25 | Year) | 9. Birthpl Count | ace (State or Foreign |
| Directo | r | 223-56-5232 X M 2 F 65 | Yrs. | Working Days | φ. | L 25 | 43 | | VA |
| pur w | | Usual Residence of Decedent 10a. State 10b. County 10c. City | , Town or Lo | cation | | | | 10 | d. Inside City Limits |
| faryla fsho | ٥ | MD NA | | imore | | | | | 1 XYes 2 □ No |
| the N | Director | 10e. Street and Number | Dare | 10f. Zip Code | | 1 | 0g. Citizen of | What Count | ry? |
| IIIQ Z IZ I 35-0030 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examination and the notified at | | 3721 Oak Ave | | 2120 | 7 | | | S.A. | |
| death ms 2 | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S | S. 13. | Was Decedent of Hispar If Yes, specify Cuban, M | | fy Yes or No- | 14. Rac | e - America | |
| or ite | Fu | Armed Forces? 1 ☐ Never Married | | | pec <i>ify:</i> | can, etc.) | | ck, White, e | |
| ours a | d by | 3 Widowed 4 Divorced Year or Dates: | | 7 La 1 es 2 A 1 10 3 5 | Jecny. | | Specif | | ack |
| 72 h | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Dece (Give | dent's Usual Occupation kind of work done during DO NOT use retired) | n g most of working | | 16b. Kind of B | usiness/Ind | ustry |
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| d be file ental Hy ked oth | To Be | Willie Woodley Sr. | | Ac | die Ba | nks | | | |
| should Mind Mind Mind Mind Mind Mind Mind Min | 1 | 19a. Informant's Name/Relationship (Type. Print) | 19b. Maili | ng Address (Street and I | Number or Rural I | Route Numbe | r, City or Town | State, Zip | Code) |
| alth a 27 is sr train | | Kathleen Woodley-Wife | 3721 | . Oak Ave, | Balti | more, | Md 2 | 1207 | |
| of He item | | 20a. Method of Disposition 20b. P | | sition (Name of matory or other place) | Dat | | 20c. Location | City or To | vn, State |
| rmit. Pages partment of portant: If it py injury or o | | X□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | | Zion | 9/3/2 | 1 8OC | Baltim | ore, | Md |
| partilliore, Interlylation ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinst must be notified at | ġ | 21 Signature of Funeral Service Licensee | M = | 2. Name and Address of arch F/H W | Facility | | | | |
| 0 25 E 6 | Si . | Proming v. Sugar | 43 | 00 Wabash | Ave | Balti | more, | md | 21215 |
| | | 2 a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. | n. Do not en | er the mode of dying, su | uch as cardiac or | respiratory ari | rest, | | Approximate Interval Between Onset and Death |
| Physician | _ | Imm diate Cause (Final distase or condition | tatic | Colon Ca | ncor | | | | Offset and Death |
| /Medica Examine | | resulting in death) Due to (or as a consequence) | uence of): | | | | | | |
| LXamille | | Sequentially list conditions, b. | same of | | | | | | |
| ted rsit | Examiner | Sequentially list conditions, and the sequentially list conditions, and the sequential list conditions, and the sequential list conditions. Due to for as a consequence of the sequential list conditions. Due to for as a consequence of the sequential list conditions. | dence on: | | | | | | |
| icate be executed physician and the burial-transit | xar | that initiated events c. Due to (or as a consequence of the consequence) | uence of): | | | | | | |
| te be ex | dical E | | | | | | | | |
| | edic | 0. | | | | | | | |
| w requires that the death certifiches is a strength of the attending should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna | | 75-4 | | | 23d. Da | te of delive | ry |
| death death | icia | in the past 12 months? 1 ☐ Ves 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal | | ☐ Ectopic pregnancy ☐ Other <i>(specify)</i> | | | M | onth | Day Year |
| by th | hys | 9 Unknown | | | | | | | |
| es that general se de | by F | Part II. Other significant conditions contributing to death but not resu | ulting in the u | nderlying cause given in | Part I. | | | | e cause of death? |
| law requires t as been signe 2 should be o | Completed | Diabotos Mollits | | | | 1 U Y | es 2∐No | 3∐ Prob | ably 4 Unknown |
| law r las be | ple | | | | | 24a. Was a | | Were autor | osy findings available inpletion of cause of |
| The cate h | Son | | | | | perfor 1 ☐ Yes | med? 2 X No | death? 1 ☐ Yes | 2 □No |
| vital neck sician: The law s certificate has t lirector, page 2 s | Be | 25. Was case referred to medical examiner? | | | . Place of Death (| Check only or | пе) | | SLMComic |
| Physical direction | P. | | ER/Outpatie 28b. Time o | | 1 ☐ Nursing Home | | • | | 110SPICE |
| ding F. After | ion | 1 Natural 5 Pending (Month, Day, Year) | Injury | f 28c. Injury at Work? M 1 ☐ Yes | | a. Describe n | ow injury occur | rea | |
| Attending Physician: The I at death. ector: After this certificate his by the funeral director, page | ical | 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury At he | me farm st | | | f Location (S | treet and Num | ber or Bura | l Route Number, |
| after after Dire | Certification: To | 4 Homicide determined building, etc. (Specific | y) | , | | City or Tow | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno and manner stated. | wledge, deat tion and/or in | h occurred at the time, o | date and place, ar on, death occurred | nd due to the | cause(s) and n | anner as s and due to | tated. the cause(s) |
| omple | Med | 29b. Signature and title of certifier | | 29c. License nui | mber | | 29d. Date signe | ed (Month, I | Day, Year) |
| ->F0 | | Meliah Gleve Do | | H 459 | 3/ | | Sapte | smbe | er 4,2008 |
| | | 30. Name and address of person who completed cause of death (Item | 1 23a) (Type, | D-1-1) | | | | | |
| 1 | | Doberah Merce 25M | AZN S | STRIZT R | ESTENS7 | cun | MO | | |

State Registrar 31. Date filed (Month, Day, Year) SEP 0 8 2008

37 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 07.03 PM SEPTEMBER 03 2008 Frances G. Zimmerman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SAINT AGNES BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 1 3 F 83 Dec. 18, 1924 Maryland 219-16-9236 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number death with a or ms 23a or must b USA 14. Race - American Indian, 6000 Keithmont Court 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2K No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dental Dental Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H tem 27 Is marked oth Be Frank Zanto, Sr. Anna Mackowiecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 215 W. Medwick Garth; Catonsville, MD 21228 Mary Zwingelberg Niece : If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 Donation 5 Other (Specify) St. Stanislaus Cem. nislaus Cem. 9-8-2008 Baltimore, Maryland
22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREUMONIA **Physician** MULTILOBAR SKAD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE Box 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERY CORONARY DISEASE 1 Tyes 2 TNo 3 TProbably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an cate has t page 2 s autopsy performed' certificate 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 0 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending to hours after death. Division 1 Natural 5 ☐ Pending investigation n 24 hours arter control in 24 hours arter control in 24 hours are control in 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 17% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P22004 MD Amushak SEPTEMBER 03 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUSHA IJER, SAINT AGINES HOSPITAL, 900 S CATON AVE, BALTIMORE MOZIZZA 32 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 08 2008

Registrar

68760

RMAR P.O.

W

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 03: 30A M VICTORIA ALEXANDRIA AUGUST ZITTLE 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR 5. Social Security N HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 1, 1916 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 F Director 92 Maryland 215-01-5365 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show notified Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 21061 USA 1423 Gordon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White ģ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mee College (1-4or 5+) Elementary/Secondary (0-12) 11 0 telephone operator communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Balsis Ursula Stepanavicius 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Tulip Oak Court Linthicum, MD Victoria M. Zittle/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from Staffa 4 Donation 5 Other (Specify) Konal State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or andition resulting in death) **Physician** SEPSIS SECONDARY TO URINARY TRACT INFECTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off Examine law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown 9 Unknown by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed DISEAS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate I 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို this funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After the Hospital or Attending Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) RES 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOURABH ERMA 3001 HANOVER STREET, BALTIMURE, MD-21225 31. Date filed (Month, Day, Year) 325Registrar's Signature SEP 0 8 2008 Registrar

08-06252

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 28690

| | State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. |
|--|--|
| Physician/ edical Examiner | 1. Decedent's Name (First, Middle,Last) Mario Aybar 2. Date of Death Month Day Year August 15, 2008 3. Time of Death 0824 hrs |
|) | 4a. Facility Name (if not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Death Bethesda 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 578-04-6171 6. Sex 1 Age (In yrs. last birthday) 80 Yrs. 1 Hours 1 Year 1 House 24Hrs. 1 House 24Hrs. 1 House 24Hrs. 2 Hours 1 Hours 24Hrs. 2 Hours 1 Hours 24Hrs. 2 Hours 24Hrs. 2 Hours 24Hrs. 2 Hours 24Hrs. 2 Hours 24Hrs. 3 Hours 24Hrs. 3 Hours 24Hrs. 3 Hours 24Hrs. 4 Hours 24Hrs. 2 Hours 24Hrs. 3 Hours 24Hrs. 4 Hours 24Hrs. 4 Hours 24Hrs. 4 Hours 24Hrs. 4 Hours 24Hrs. 4 Hours 24Hrs. 4 Hours 24Hrs. 5 Hours 24Hrs. 5 Hours 24Hrs. 5 Hours 24Hrs. 6 Hours 24Hrs. 6 Hours 24Hrs. 7 Hours 24Hr |
| faryland 28a-f show any. lat once. | Usual Residence of Decedent 10a. State |
| the Maryland a or 28a-f sh tifled at one Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1135 University Blvd. #711 20902 United States |
| or items 23s must be not Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. |
| 2 hours afte "natural", "natural", l'Examiner | 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Specify: Peruvian Specify: Other 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |
| 5-0036 Iled within 72 hour Hygiene. 4 other than "natur the Medical Exar | 6 Maintenance Technician Residential 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |
| MD 2121 d 2 should be fi lith and Mental n 27 is marked umatic event, | Alejandro Aybar Idolia Vivanco 19a. Informant's Name/Relationship (Type, Print) Alicia Bellido-Sister 12901 Esworthy Road, Gaithersburg, MD 20878 |
| Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traumingury or other tr | 20a. Method of Disposition 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Removal from State 20c. Removal from State 20c. Removal from State 20c. Removal from State 20c. Removal from State 20c. Removal from State |
| Baltim permit Pa Departmen Important injury or o | 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Simple Tribute MD 20852 1040 Rockville Pike, Rockville |
| Physician /Medical xaminer | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death |
| ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause |
| executed an and al - transit ical Examine | (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): d. |
| 8 [5.E] Q | UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was deceded pregnant in the |
|). Box 68760 the death certificate to yothe attending physical physical for use as the broad | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown |
| rds, P.O. B requires that the de been signed by the hould be detached to leted by Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bledical Certification: To Be Completed by Physician/Me | 24a. Was an autopsy findings available autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No |
| 1 of Vital Recoi | 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 26. Place of Death (Check only one) 1 ✓ Yes 2 No Cher's Nursing Home 5 Residence 6 Other: |
| Division of spiral or Attending P tours after death. Iffilled in by the function: Certification: Certification: | 27. Manner of Death 1 Natural 5 Pending 1 Nestigation Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Pedestrian struck by tow truck 28d. Describe how injury occurred Pedestrian struck by tow truck 28d. Describe how injury occurred Pedestrian struck by tow truck |
| Divisior To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the ledical Certification | Suicide 6 Could not be determined (Specify) Local Street Georgia Avenue/Reedie Dr., Wheaton, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| > | (Check only one) 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |
| OCME 2 | O.C.M.E. August 16, 2008 30. Name and address of person who completed cause of death (Item 23a) |
| State | |
| Registrar DHMH 17 Rev 1/2001 OCME 2006 | ORIGINAL |

| | | | For | State of Mar | yland / | | | | | ntal Hyg | iene | | |
|------------|---|----------------|--|--|---------------------|-------------------------|--|----------------------------|-------------------------------|-----------------------------------|---------------------------|----------------------------------|--|
| | | | State Registrar | | | Cer | tificate of I | Death | | | eg. No. 🤈 | 008 | 28691 |
| | Physici | an | Decedent's Name (First, Middle, Last | _ | | | | | 2 | Date of Deat Month | Day | Year | 3. Time of Death |
| 6. 4. | /Medic | al | Mildred Anne 4a. Facility Name (If not institution, give | | ea11 | | 41. O't. Terre | | | August | | 2008 | 11:10 A ^M |
| Å. | Examin | er | 5433 Solomons Isl | | | | 4b. City, Town, or | thian | or Death | | | unty of Death | ndo1 |
| | Funeral | | Social Security Number 6. Se | x 7. Age (| (In yrs. last b | oirthday) | If Under 1 Year | If Under | | Date of Birth | | ne Aru | lace (State or Foreign |
| Н | Director | 8 | 217-38-8774 | ^{□M 2} XF 9 | 93 | Yrs. | Months Days | Hours | Min. | (Month, Day, 05-29- | 1915 | Mar | vland |
| | pu » | 5 | Usual Residence of Decedent 10a. State 10b. County | 11 | 10c. City, To | wn or Lo | nation | | | | | | 04 1-14-04-11-4- |
| | shov shov | J. | | | ruc. City, 10 | WITOFLO | | | | | | [' | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | the N 28a-f notifie | Director | MD Anne Aru 10e. Street and Number | indel | | | Lot 10f. Zip Code | hian | | 1 | Og Citizon | of What Cour | 71 |
| | with 3a or t be | | 5433 Solomons Isl | land Dand | | | | 711 | | 1 | og. Omzen | | шу: |
| | ms 2: | Funeral | 11. Marital Status | 12. Was Decedent Eve | er in U.S. | 13. V | 207 Vas Decedent of H | ispanic Ori | igin? (Specif | y Yes or No- | | USA Race - Americ | |
| 9 | or Ite | | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X | 1 | | f Yes, specify Cuba | | | ean, etc.) | | Black, White, | etc. |
| 5 | ours iral", | d by | 3 Widowed 4 ☐ Divorced | Year or Dates: | | | !∐Yes 21√ No | Specify: | | | Sp | ^{pecify:} Whi | te |
| 21215-0036 | "natu | Completed | 15. Decedent's Edu (Specify only highest grad | ication le completed) | 16 | a. Deced | lent's Usual Occup kind of work done o OO NOT use retired | ation during mos | st of working | 1 | 16b. Kind | of Business/Inc | dustry |
| 12 | withir ene. than | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | | _ | memaker | " | | | OW | n home | |
| מ ס | be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | Ö | 17. Father's Name (First, Middle, Last) | | | | | 18. Mothe | er's Name (F | irst, Middle, I | | | |
| <u>a</u> | should be filed and Mental Hygi marked other matic event, t | To Be | James Joshua | Paddy | | | | Saı | rah | Alice | Tur | ner | |
| Maryland | should and Men s marke | | 19a. Informant's Name/Relationship (T) | | 19 | b. Mailin | g Address (Street | and Numbe | | | | | Code) |
| | and 2 ealth a n 27 Is | | Gerald L. Ball, | son | | 113 | Bayard F | Road, | Lothi | an, MD | 2071 | .1 | |
| ore | - I 5 5 | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ i | Removal from State | 20b. Place cemei | of Dispos tery, cren | sition (Name of natory or other plac | e) | Date | 9 | 20c. Locat | ion - City or To | wn, State |
| altimore, | Pag tment tant: jury c | | 4 Donation 5 ☐ Other (Specify, |) | Mt. | | Cemeter | | 08-23- | | | nian, M | |
| ga | permit. Pages Department of Important: If it any Injury or conce. | | 21. Signature of Funeral Service Licens | R. Gro | ~ | | Name and Address 8325 Mt. | | | | | | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | ications that caused the ne cause on each line. | ne death. Do | | er the mode of dyin | g, such as | cardiac or r | | | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. Due to (or as a c | consequence | e of). | Sepsis Ostormy | | | | | | 24 h 15 |
| | Examiner | | | Due to (or as a c | consequence | c oij. | 05 GO My | chites | | | | | Iweek |
| | D # | ner | Sequentially list conditions, if any, leading to immediate | Due to (or as a c | consequence | e of): | | | | | | | |
| | ecute and trans | Examin | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | | | |
| 60, | icate be executed physician and s the burial-transit | | and a second sec | Due to (or as a o | consequence | e of): | | | | | | | |
| 28/60 | physicate sthe | dical | | d | | | | | | | | | |
| XOA | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bural-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome pf | | | | | | | 23d | . Date of delive | erv |
| ň | death e atte d for | icia | in the past 12 months? 1 ☐ Yes 2 ☑ No | 1□Live birth 2 4□Pregnant at tir | | | Ectopic pregnancy Other <i>(sp</i> ec <i>ify)</i> | | | | | Month | Day Year |
| 5 | at the by the tache | hys | 9 ☐ Unknown | 9∐Unknown | | | | | | | | | |
| S, | requires that the een signed by th nould be detache | by P | Part II. Other significant conditions co | = | _ | in the un | derlying cause give | en in Part I | l. | 23e. Did tot | acco use | contribute to the | ne cause of death? |
| ecords, | een si | | Blahermers | Benergha | 3 | | | | | 1 □ Ye | es 2 🖎 N | No 3 ☐ Prot | ably 4 Unknown |
| ပ္ | a a a | Completed | | | | | | | | 24a. Was a autops | y | prior to co | psy findings available mpletion of cause of |
| <u> </u> | ate pag | Co | | | | | | | | perförr 1∐ Yes 2 | ned? 2 🗷 No | death? 1 ☐ Yes | 2 No |
| VII | Physician: The la this certificate ha ral director, page 2 | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othe | or. | · | Check only on | | | |
| Ö | Phy this | ۴. | 1 Yes 2 No 27. Manner of Death | 1 ☐ Inpatient 28a. Date of Injury | | Outpatient . Time of | t 3 DOA Out | 4 🗆 Nü | | 5 Reside | | Other (Specif | y) |
| SION | ndlng th. :: Afte e fune | tion | 1 ★ Natural 5 Pending 2 Accident investigation | (Month, Day Y | Year) | Injury | Worl | k? Yes 2 🗍 | | | ,, | | |
| <u> S </u> | Atter | ifica | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of injury building, etc. | / - At home, | farm, stre | eet, factory, office | | 28f | | | lumber or Rura | il Route Number, |
| <u> </u> | pital or Atten | Certification: | | bunding, etc. (| (Opecity) | | | | | City or Towr | i, Siale) | | |
| | 24 hos Fun etely | edical | 29a. Certifier (Check only one) 1 | sician: To the best of r iner: On the basis of ex and manner state | xamination a | ge, death and/or inv | occurred at the ting estigation, in my o | ne, date ar pinion, dea | nd place, and ath occurred | d due to the ca at the time, d | ause(s) an ate and pla | d manner as s ace, and due to | tated. o the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier |) | | | 29c. License | | - | | | igned (Month, | |
| | | } | 1 Wand |)an | | | 03 | 258 | 3 | 6 | lugus | X2120 | 58 |
| ł Ri | w 4 | | 30. Name and address of person who co | empleted cause of deal | th (Item 23a | (Type, F | Print) Simble R | Ed, | West | Riv | er | Tziza | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 2 2008 | Signature | H | South 0 | / | | | 1 | | |
| | ricgisti | -11 | HOU D | ~ -0000 | PELAGIA | 10. | The state of the s | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^{Day}9, AUGUST Ž0008 CLEA BRADFORD-SILVERLIGHT 8:58 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 2, 1941 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Missouri 499-36-0810 67 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be rediffed at Silver Spring MD Montgomerv Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mantal Hyghene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic and 3928 Tynwick Drive 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed vrs Recording Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard H. Bradford Elizabeth A. Coleman ည 19a. Informant's Name/Relationship (Type. Print) (Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4631 Kingwood Drive, Bealeton, VA 22712 Clea McKinney (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem Park 8/22/08 Rockville. MD 4 □ Domation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Sign were of Funeral Service Licensee ena 246 N. Washington St., Rockville, MD 20850 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Carcinoma Breast Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the as use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year 5 Other (specify) □Yes 2\□No P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After **M**Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Potel Layanti D 052586 8/20/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti L. Patel, M.D. 1500 Forest Glen Aven, Silver Spring, MD 20910 32. Pogistrar's Signature 31. Date filed (Mont State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:40 A 2008 George H. Beuchert, Jr. 19, Aug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 5949 Searl Terrace Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
April 15,1924 Wash., 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 579-20-5884 84 D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits t be notified at 10a. State 10b. County 1 X Yes 2 No Director Bethesda Maryland | Montgomery death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20816 U.S.A. 23a 5949 Searl Terrace "natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Tyes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Practice Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Sheehy George H. Beuchert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5949 Searl Terrace Bethesda, Maryland 20816 Mae Beuchert/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State August 23, 4 □ Donation 5 □ Other (Specify) St. Mary's Cemetery Washington, D.C. 2008 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Fureral Service Len Kin 78 2222 Wisconsin Ave., N.W. Washington, D.C.20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure Days /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş Dementia, Alzheimer's type 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Hospital: 1 Tes 2√ No 2 ER/Outpatient 3 DOA ဥ 1 ☐ Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending Patter death. After 5 Pending investigation 1 🖎 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number 2 Aug. 19, 2008 D40216 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7625 Wisconsin Ave. #101 Bethesda, MD 20814 Dennis Cullen, M.D. 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

| imothy G. Beilis | • | State of Maryland / Department of Health and Me 1-For State Registrar Certificate of Death | ental Hy | | g. No. 20 | 08 2869 | | | | |
|--|----------------|---|--|--------------------------------|------------------------------------|--|--|--|--|--|
| Physicia Medical Examin | n/ | Decedent's Name (First, Middle,Last) | | Date of Deat | n Day Year | 3. Time of Death 2130 hrs | | | | |
| wedicai Examin | | TIMOTHY GORDON BEMIS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location | | August 31 | 4c. County of De | | | | | |
| | | 219 South Washington Street Easton | | | Talbot | | | | | |
| Funeral Director | - 1 | | Onder 24Hrs. Ours Min. | 8. Date of Birt | h(MM/DD/YYYY) 9. For ,1946 | Birthplace (State or eign Country) PA | | | | |
| auò | - | Usual Residence of Decedent 10a. State | | | | 10d. Inside City Limits | | | | |
| 8 4 | 5 | MD TALBOT NEAVITT | | | | 1 Yes 2 X No | | | | |
| Maryla | Director | 10e. Street and Number 10f. Zip Code | | 10 | g. Citizen of What C | ountry? | | | | |
| with the Maryland ns 23a or 28a-f sho be notified at once. | | 6431 BOZMAN-NEAVITT ROAD 21652 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C | Origin? (Spe | cify Yes or No- | US | A nerican Indian, Black, | | | | |
| 5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once | Funeral | 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexic | | | White, etc | | | | | |
| s after | اھ | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No special Divorced or Dates: | | | Specify: | WHITE | | | | |
| 5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examine. | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Givening most of working life. DO NO | during most of working life, DO NOT use retired) | | | | | | | |
| 0036 vithin 7 ene. er than Medica | ğ | 12 5+ FREIGHT SALES CON | | ULTANT RAILROAD | | | | | | |
| | Be Co | | | First, Middle, N Y WAGNE | Maiden Surname) | | | | | |
| | 라 | 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and N | | | | ate, Zip Code) | | | | |
| e, MD I and 2 sho Health and item 27 is | ļ | JILL A. BEMIS/WIFE PO BOX 68, NEAV 20a. Method of Disposition (Name of cemetery, | | | 2 20c. Location - City | or Town Chate | | | | |
| Baltimore, permit. Pages I an Department of Hea Important: If iter | | 1 Burial 2 X Cremation 3 Removal from State crematory or other place) | | Date | | | | | | |
| Baltimo permit. Page Department or Important: injury or ott | + | 4 Donation 5 Other Specify: CHESAPEAKE CREMATION 21. Signature of Funeral Service Licensee 22. Name and Address of Fac | VILLE, MD | | | | | | | |
| Dep Derr Injury | 4 | Joseph M. Osteocyky C.F.S.R FELLOWS, HELFE | L HOME PA | | | | | | | |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line. | as cardiac or i | respiratory arre | est, shock, or heart | Approximate Interval Between Onset and Death | | | | |
| -xaminer | | Immediate Cause (Final disease or condition resulting in death) Asphyxia Due to (or as a consequence of): | | | | Death | | | | |
| | | Sequentially list conditions, b. | | | | | | | | |
| | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Co. | | | | | | | | |
| urted id ansit | Exa | events resulting in death) Last Due to (or as a consequence of): d. | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | dica | X UNPENDED AMENDED 23a,27,28a-f, perME g883 IF FEMALE: 23c. If yes, outcome of pregnancy | 9/11/ | 08 TT | | | | | | |
| 3760 ificate to g physis s the bu | Me i | 23b. Was decedent pregnant in the 1 Live birth 5 Fotol death 3 Fotol | topic pregnan | CV | 23d. Date of deli | very Day Year | | | | |
| x 68 tth certi | icial | past 12 months? 4 Pregnant at time of death 5 Other (Specify) | topic pregnan | Cy | Month | Day Teal | | | | |
| that the deathed by the attended for | Physician/I | 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in | n Part I | 23e. Did to | bacco use contribute | to the cause of death? | | | | |
| , P.C res that signed! | হ | | | 1 Yes | 2 No 3 F | Probably 4 🗹 Unknown | | | | |
| cords law requi | Completed | 8. | | 24a. Was autop | | autopsy findings available to completion of cause of | | | | |
| tal Reccition: The la | 틹 | | | 1 V Yes | med? death 2 No 1 ✔ | | | | | |
| ital Re | 8 B | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other₁ | | | Residence 6 0 | ther: | | | | |
| n of Vi | 의 | 1 ✓ Yes 2 No Injury 2 ✓ Excoupation 3 DOA 4 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at W | - Nursing | | now injury occurred | rrier. | | | | |
| ion trendin feath. tor: A | aţio | Pending Investigation Fnd 8/31/08 Fnd 8:10pm 1 Yes 2 X No subject asphyxiate | | | | | | | | |
| Divis al or A s after al Direc | Certification: | 3 Suicide 6 X Could not be determined (Specify) Specify Specify Specify Specify Suicide at home | g, etc. 2 | 28f. Location (S or Town, S | Street and Number or tate) 6431 Bo | Rural Route Number, City znan Neavitt | | | | |
| Hospit 24 hour Funera | | 4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and | | | e(s) and manner as s | stated. | | | | |
| Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / | Medical | one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death and manner stated. | | the time, date | | | | | | |
| | Σ | 29b. Signature and title of certifier 29c. License numb O.C.M.E. | nber | | 29d. Date signed (September 1, | · · · | | | | |
| | - | 30. Name and address of person who completed cause of death (Item 23a) | | | | | | | | |
| | | Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, | Baltimore | , MD 2120 | 1 | | | | | |
| Sta Registr | | 31. Date filed (Month, Day, Year) . 32. Registrar's Signature | | | | | | | | |
| 1.091011 | - | | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

| | | | For State Registrar | State of M | laryland | | rtment of F tificate of a | lealth and N Death | | giene Reg. No. 2 | 0.8 | 28695 |
|-------------------|--|----------------|---|--------------------------------------|-----------------|-----------------------------|---|---|------------------------------|---------------------|-----------------------|---|
| | | | Hegistrar Decedent's Name (First, Middle, La | st) | | 001 | imodio or i | | 2. Date of De | | 00 | 3. Time of Death |
| 3. | Physicia | | | , | | | | | Month August | Day 21 | Year 008 | 07:55 AM |
| · | /Medic Examin | | Enos Lapp Detwei 4a, Facility Name (If not institution, giv | | r) | | 4b. City, Town, o | r Location of Death | August | | y of Death | 1 07.55 AM |
| | Examin | ÇI | Calvert Manor He | althcare | Center | _ | Risir | ng Sun | | Ce | cil | |
| | Funeral | | 5. Social Security Number 6. S | Sex 7. A | ige (In yrs. la | | If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir (Month, Da | th | | place (State or Foreign |
| | Director | | 192-20-1505 | XOXM 2□F | 81 | Yrs. | Months Days | Hours Min. | Dec. 4 | | | sylvania |
| | Pu , | | Usual Residence of Decedent | | Tago City | , Town or Lo | oation | | | | 1 - | 10d. Inside City Limits |
| | anylau show d at | 7 | 10a. State 10b. County | | Toc. City | , TOWITOI LO | cation | | | | | 1 ☐ Yes 2 ☑ No |
| | Ba-f otifie | Director | Maryland Cecil | | N | North 1 | | | | 10g. Citizen of | Mhat Cour | |
| | with t | ä | 10e. Street and Number | | | | 10f. Zip Code | | | | | |
| | sath | eral | 59 Zion Acres Ro | ad 12. Was Deceden | t Ever in U.S | S 13 V | 21901 | | | United 1 | State | |
| | item item | Funeral | 11. Marital Status 1 Never Married 2 Married | Armed Forces | ? | J. 10. 1 | f Yes, specify Cub | lispanic Origin? (Sp an, Mexican, Puerto | Rican, etc.) | Bla | ack, White, | |
| 39 | irs af | ρ | 3 Widowed 4 Divorced | If Yes, Give Year or Dates | US Nav | у Т | 1 ☐ Yes 🏋 No | Specify: | | Speci | ify: Wh | ite |
| 21215-0036 | e filed within 72 hours after death with the Maryland Yugiene. other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at | Completed | 15. Decedent's E | ducation | | 16a. Deced | dent's Usual Occup | nation | kina | 16b. Kind of E | Business/In | dustry |
| 212 | e. an "r Med | ple | Elementary/Secondary (0-12) | College (1-4o | r 5+) | life. L | DO NOT use retired | during most of word d) | Ning | Manu | factu | ring |
| 2 | er the | Con | 8 | | | Bencl | h Floor F | | | | motiv | e |
| ng | be file | Be (| 17. Father's Name (First, Middle, Last | | | | | 18. Mother's Nam | , | * | ime) | |
| <u> </u> | should band Ment and Ment s marked umatic e | ပ္ | Enos Lapp Detwe | | | 1 | | | es Maud | | | |
| Maryland | < 2 € 2 € 2 € | | 19a. Informant's Name/Relationship (Margaret E. Bossa | | htor | | | and Number or Ru Road, N | | | | |
| | 1 and Health sm 27 ther to | | 20a. Method of Disposition | Lu / Daug | Look D | (ann of Dinns | -:N /Afa f | | | 20c. Location | | |
| altimore, | Pages nent of f int: If ite | | 1 X Burial 2 ☐ Cremation 3 ☐ | | e Sta | emetery crer age Lin | natory or other place ne Baptis ery | Augu | | | • | |
| ≣ | permit. Pag Department Important: I any Injury o | | 4 □ Donation 5 □ Other (Special 21. Signal e Fun and Service Lieu | | | | ery 2. Name and Addre | | | Rising Funeral | | Maryland |
| Ba | Depa Impo any t | | 21. Signal et la distribution de la constantina della constantina | | | | | | | | | ry1and21901 |
| | | | 23a. Part1. Enter the disease, or com | nolications that cause | ed the death | | | | | | . , | Approximate Interval Between |
| | Dharista | | shock, or heart failure. List only Immediate Cause (Final | one cause on each | line. | | _ | | | | | Interval Between Onset and Death |
| - | Physician / /Medical | | disease or condition resulting in death) | a. Due to (or a | s a consequ | ience of): | Disea | re- | | | | 710 years |
| | Examiner | | | Due to (o) a | is a consequ | terice or). | Disea + infec | Lore | | | | 1 wook |
| <i>s</i> · | | ē | Sequentially list conditions, if any, leading to immediate | b. Diserts (or e | is a nunseign | leinau of): | Time | 71.01 | | | | - wav |
| | uted d ansit | Examiner | Hany, loading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | | |
| oʻ | exec an an rial-tr | Exa | resulting in death) Last | Due to (or a | ıs a consequ | uence of): | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | dical | | _ d | | | | | | | | |
| ဖ | ntifica ng ph as tl | | IF FEMALE: | | | | | | | | | |
| . Box | ath ce tendi | an/I | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcom 1 ☐Live birth | | ideath 3 |]Ectopic pregnanc | у | | | ate of deliv | very Day Year |
| | The law requires that the death certif ate has been signed by the aftending age 2 should be detached for use a | Physician/M | 1 Yes 2 No | 4□Pregnant 9□Unknown | | eath 5 | Other (specify) _ | | | " | | Duy |
| P.0 | hat th d by l letach | Phy | Part II. Other significant conditions | contributing to death | hut not resu | ulting in the U | nderlying cause giv | ven in Part I | 23e Did | tohacco use co | ntribute to | the cause of death? |
| Records, | ires ti signe i be c | by | Tak ii. Other significant conditions | sommouning to death | Dut Hot 100 | and in the ti | naonymy cadoo gn | TOTAL CALL | | Yes 2 110 | | bably 4 Unknown |
| 0 | requ | Completed | | | | | | | | 1 | | . – |
| ě | ne faw has I ye 2 s | mpl | | | | | | | 24a. Was | | prior to co death? | opsy findings available ompletion of cause of |
| a | Th icate r, pag | | | ı | | | | | 1□ Yes | 2 No | 1 ☐ Yes | 2□ No |
| Division or Vital | nysician: The Is nis certificate ha I director, page 2 | Be | 25. Was case referred to medical examiner? 1 Yes 2 PNo | Hospital: | | ED/Outs-tis- | t all DOA Oth | 26. Place of Dea | | | | |
| ō | Physic ruthis real di | ٠ <u>.</u> | 27. Manner of Death | 1 ☐ Inpa | | ER/Outpatier 28b. Time o | IL 3 DOA | 4 Mursing H | | how injury occu | | ify) |
| on | ding Ph h. After th funeral | tion | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio | | Day Year) | Injury | f 28c. Inju Wo M 1 | rk?]Yes 2∐No | | | | |
| /ISI | Atter deat | fica | 3 Suicide 6 Could not b | e 28e. Place of i | injury - At ho | ome, farm, str | reet, factory, office | | | | nber or Rui | ral Route Number, |
| á | al or | Certification: | 4 Homicide determined | building, | etc. (Specify | <i>y)</i> | | | City of 10 | own, State) | | |
| | Hospital or Attending I 44 hours after death. Funeral Director: After tely filled in by the funer | | | hysician: To the bea | | | | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director. | Medical | one) | and manner | | on and/or In | | | area at the time | | | |
| | With To 1 | Σ | 29b. Signature and title of certifier | 2.0.1 | / | a . - | 29c. Licens | | | 29d. Date sign | ned (Month | , Day, Year) |
|) | | | fungh h | Will. | w 0 | com | Po | 044513 | | 8 | 25 | 2008 |
| | , | | 30. Name and address of person who | completed cause or | f death (Item | 23a) (Type, | Print) | | 200 | 5 | n) h | un21911 |
| 4 | HAIVA | | 31. Date filed (Month, Day, Year) | 32. Rahi | strar's Signa | ture | 100011 | 76 61 | - K(>1A | 7 -0 | 10.1 | 2008 |
| Ř. | Sta Registr | | AUG 2 6 | 2008 | ALLES. | D. B | bere | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 19 3:00 A^{M} S. DiMarco 2008 Marion August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Riva Terrace II Assisted Living Annapolis If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 04–16–1926 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 X F 82 Director 274-20-9084 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han account. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2 X No **Funeral Director** Huntingtown Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 121 Cox Road 20639 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 ₩ Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government executive secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Thomas Sheridan Mary Elizabeth Seabolt Eugene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Cox Road, Huntingtown, MD 20639 Lawrence M. DiMarco, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 08-20-08 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was dece ent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Ves 2 □ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should ECTI 134a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate I Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 6 Other (Specify) After this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) within 24 and manner stated. and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatur

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAL

32. Registrar's Signature

DIGI

31. Date filed (Month, Day, Year)

ARVIND DESAI

| | | | | | | | | c. Ensure A Health and N | • | | • | | |
|----------------|--|------------------|---|-----------------------|--------------------------------------|------------------------|--|---|-------------------------------|------------|----------------------------|--|-----|
| | | | 1 - For State Registrar | Otato | or warylar | | rtificate of | | | Reg. No | 200 | 8 2869 | 1 |
| | | e . | Decedent's Name (First, Middle, L. | .ast) | | | | | 2. Date of Dea | ath | L 0.0 | 3. Time of Death | _ |
| н | Physici /Medi | | SHELVA J | EAN | EVANS | | | | August | 20 | | 3:17 P N | М |
| 1 | Examir | | 4a. Facility Name (If not institution, g | ive street and n | umber) | | | or Location of Death | 1 | 4c | . County of Dea | ath | |
| Aller . | 4 | | 297 Somers Cove | Apartme | ents | | Cr | isfield | | | Somerse | t | |
| | Funeral | | | Sex 1 ☐ M 2X F | 7. Age (In yrs. | last birthday, Yrs. | If Under 1 Year Months Days | | 8. Date of Birl (Month, Da | v. Year) | C | rthplace (State or Foreig country) | gn |
| | Director | | 218-34-7572 Usual Residence of Decedent | | 69 | 115. | | | October 2 | 26, 1 | .938 14 | Marýland | |
| | land ow It | | 10a. State 10b. County | | 10c. Cit | y, Town or L | ocation | | | | | 10d. Inside City Limit | ts |
| | Mary -f sh fied a | tor | Maryland Somers | set | | | Crisfiel | d | | | | 1 X Yes 2 □ No | Ю |
| | r 28a | irec | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Cit | izen of What C | ountry? | _ |
| | h with | a D | 297 Somers Cove | Apartme | ents | | | 21817 | | | U.S.A | . • | |
| | ems dear | Funeral Director | 11. Marital Status | 12. Was De Armed F | cedent Ever in U | .S. 13. | Was Decedent of | Hispanic Origin? (Sp ban, Mexican, Puert | pecify Yes or No | - | 14. Race - Am Black, Wh | | _ |
| 98 | or it | J. | 1 Never Married 2 Married | 1 ⊡ Yes If Yes, G | 3 QNO Give | | 1 ☐ Yes 2 【 No | | | | Specify: W | | |
| 8 | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at | d by | 3 ☐ Widowed 4 ☑ Divorced | Year or | Dates: | 10- D | dent's Usual Occu | | | 405-16 | | | _ |
| 75 | C - 0 | lete | 15. Decedent's (Specify only highest of | rade completed | | (Give | kind of work done OO NOT use retire | e during most of wor ed) | king | 100. N | ind of Business | s/maustry | |
| 21215-0036 | be filed within 72 hours after death with the Marylar ttal Hyglene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed | Elementary/Secondary (0-12) | College | (1-4or 5+) | | maker | , | Ì | | At Ho | ome | |
| Þ | other other | BeC | 17. Father's Name (First, Middle, La | st) | | | | 18. Mother's Nam | ne (First, Middle, | Maider | Surname) | | |
| /lar | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M | 일 | Lloyd James Tyle | er | | | | Thelma | Virgini | ia B | yrd | | |
| Maryland | S E S | ľ | 19a. Informant's Name/Relationship | ral Route Numb | _ | | | | | | | | |
| ≥,′ | D # 2 T | | Tammi Reynolds | Daughte | | | | y Lane - | | | | 21853 | |
| Baltimore, | iges 1 ar it of Hea if item or other | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 | ☐Removal from | n State | cemetery, cre | osition (Name of ematory or other pl | | Date | | ocation - City o | | |
| ij | t. Pa rtmen rtant: njury | | 4 □ Donation 5 □ Other (Spec | | As | | emetery | | 23/08 | Cr | isfield | I, MD | |
| Bal | permit. Pages : Department of I Important: If ite any Injury or of once. | | 21. Signatur of Fun cal S rvice Lic Kobert H. Brac | 1/1 | fr. | B 3 | 2. Name and Add radshaw 06 W. Ma | & Sons Fu in St. – | neral Ho Crisfie | ome Ld, | MD 2181 | .7 | |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that | t caused the deat | h. Do not en | ter the mode of dy | ring, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition | A74 | eno Sci | Brot | re CAR | dutisa | Son Di | Sera | SC | Onset and Death | 2 |
| 1 | /Medical | | resulting in death) | Due to | o (or as a conseq | | | | | | | Jenn | 1 |
| 8 | Examiner | L | Sequentially list conditions, | b | | 112 | | | | | | | |
| | pe tis | Examiner | ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to | o (or as a conseq | uence of). | | | | | | | |
| _ | be executed ician and burial-transit | хаг | that initiated events resulting in death) Last | c | o (or as a conseq | uence of): | | | | | | | _ |
| 68760, | be executed sician and burial-transit | a E | | | o (01 do d 0011004 | 401100 017. | | | | | | | |
| 587 | ficate phys s the | | | d | | | | | | | | | _ |
| Box (| death certificate attending physi | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant | | utcome pf pregna | | _ | | | | 23d. Date of d | elivery | |
| | death a atte | icia | in the past 12 months? | 4∐Preg | e birth 2□Feta gnant at time of c | | ⊒Ectopic pregnan ⊒ Other <i>(specify)</i> . | су | | | Month | Day Year | |
| P.0 | at the de by the | hys | 9 ☐ Unknown | 9□Unk | nown | - | | | | | | | |
| | as the | by P | Part II. Other significant conditions | contributing to | death but not res | ulting in the | underlying cause g | iven in Part I. | 23e. Did t | obacco | use contribute | to the cause of death? | |
| ord | w require been sig should b | | | | | | | | 1/2 | Yes 2 | □ No 3□ F | Probably 4 Unknow | vn |
| င် | law r as be | ple | | | | | | | 24a. Was | | 24b. Were a | autopsy findings availab completion of cause of |)le |
| Vital Records, | 70 - | Completed | | | | | | | perfo | rmed? | death? | | |
| Vita | ysiclan: The is certificate director, pag | Be (| 25. Was case referred to medical examiner? | Hospital | _ | | 1. | 26. Place of Dea | | | | | _ |
| _ | ys dir | .0 | 1 res 2 No | Hospital: 1 | Inpatient 2 | ER/Outpatie | nt 3 DOA | ther: 4 \(\sum \) Nursing H | lome 5 Residen | dence | 6 □Other (Sn | ecify) | |

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors.

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation

2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9813

29a. Certifier (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 201 Hall Highway - Crisfield, MD Michael Atkins, M.D. 21817

State Registrar

Medical Certification:

31. Date filed (Month, Day, Year) AUG 2 2



08-06660 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rick Adam Fuller State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 31, 2008 Year 0937 hrs Medical Examiner Rick Adam Fuller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Cecil Elkton 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) If Under 1 Year **Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Foreign Country) 221-80-3579 Months Days Hours Min Director 1 / M 2 23 Yrs DE March 18, 1985 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No MD Cecil Elkton with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 1167 Appleton Rd. 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. death 1 Never Married 2 Armed Forces? Married 2 J No Yes è White 2 No hours after If Yes, Give Yea Yes Specify. Divorce "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 72 MD 21215-0036 Forklift Operator Construction filed within of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be Stephen A. Fuller Lisa A. Fuller Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Lisa A. Fuller/Mother 55 Blossum Lane, Elkton, MD 2192 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 √ Cremation 3 Removal from State Department of Important: West Chester, PA Other Specify: Ferris & Co. Donation 5 September 8, 2008 ral/Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 Approximate Interval 23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Methadone intoxication Immediate Cause (Final disease ⁷xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, 28a-f, perME, Item#5perFH, G883, 9/19/08 perME, the attending physician : X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Month Day Year Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ Yes 2 ✔ No 3 Probably 4 Unknown Narcotic use (oxycodone, morphine) Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27 Manner of Death Certification: Yes 2X No unk Natural 5 Pending Fnd 8/31/08 Fmd 8:30 alm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1167 Appleton Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide or Town, State)
Elkton, MD house (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director:
completely filled in by the f

30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

me

32. Registrar's Signature

and manner stated

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 1, 2008

0

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ĭ\$ 2008° **Physician** 10:59 PM August Fox, William George /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**∑**M 2□F Days Months Yrs. Virginia 80 08-02-1928 Director 231-22-6875 Usuef Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County in then "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Calvert Owings 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9017 Michael Way USA 20736 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a eny Injury or other traumatic event, the Mydical Examinar must, once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates: 1948-53 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 11 Federal Government stereotyper & plate maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sr. Carmines ပ George William Fox. Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9017 Michael Way, Owings, MD 20736 Geraldine L. Fox, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 08-22-2008 Davidsonville, MD 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** 2 days /Medical Examiner Cardiovascular Disease Arterlosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Tubular Necrosis - Renal Fallure 1 Tes 2 No 3 Probably 4 Unknown Completed Cerebrovascular Insufficiency Iver Fallure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Drabetes mellitur T2 1 ☐ Yes 2 ☐ No Advanced Parkinsonism 1 Yes 2 No To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 19, 2008 erald Hemen D 17245 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald P. Sterner, M.D., 19 Chesapeake Beach Rd., E., Owings, MD 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 2 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | 1- State of Maryla Registrar | | rtificate of l | | | ene g. No.2 | 3 28700 | | | | | | |
|--------------------------------|--|----------------|--|-------------------------------------|--|--|---|--|--|--|--|--|--|--|--|
| | Physici /Medio | | 1. Decedent's Name (First, Middle, Last) Elizabeth L. Godwin | | | | 2. Date of Death Month August | Day Year 20, 2008 | 7 4 7 0 - 8/ | | | | | | |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | падазе | 4c. County of De | | | | | | | |
| 1 | | | Union Hospital | | Elkton | | | Cecil | | | | | | | |
| | Funeral | 7 | 454 05 | s. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | Year) 9. Bi | rthplace (State or Foreign Country) | | | | | | |
| | Director | | 221-14-4153 | 84 Yrs. | | | March 3 | 1,1924 W | ilmington, DI | | | | | | |
| | and and | | Usual Residence of Decedent 10a. State 10b. County 10c. 0 | City, Town or Lo | cation | | | | 10d. Inside City Limits | | | | | | |
| | Maryl f sho | jo | DE New Castle | Newark | | | | | 1 ☐ Yes 2 XNo | | | | | | |
| | the notif | Director | 10e. Street and Number | ICWAIR | 10f. Zip Code | | 10 | g. Citizen of What C | Country? | | | | | | |
| | 3a ol | D | 2201 Capitol Trail | | 10 | 711 | | USA | | | | | | | |
| | deat | Funeral | 11. Mantal Status 12. Was Decedent Ever in Armed Forces? | U.S. 13. | | ispanic Origin? (Span, Mexican, Puerto | ecify Yes or No- | 14. Race - Am | | | | | | | |
| စ္ | ges 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | / Fu | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No | | Tes, specify Cube | Specify: | rtican, etc.) | Black, Wh | white | | | | | | |
| 9 | ural", | d by | 3 X Widowed 4 ☐ Divorced Year or Dates: | | | | | | | | | | | | |
| 5 | "nat "nat | Completed | 15. Decedent's Education (Specify only highest grade completed) | ı (Give | lent's Usual Occupa kind of work done o DO NOT use retired | durina most of work | ing | 6b. Kind of Busines | s/Industry | | | | | | |
| 12 | withile ene. than he M | dmc | Elementary/Secondary (0-12) College (1-4or 5+) | | | ″ nistrator | | City Di | 1 C-1 | | | | | | |
| 9 | filed Hygi 2ther ent, t | | 17. Father's Name (First, Middle, Last) | 011 | ICE admit | 18. Mother's Name | | | amond Cab | | | | | | |
| an | Mental Mental arked o | To Be | Walter Bassett | | | Bertha | (unknown |) | | | | | | | |
| ary | 2 should and Men Is marke sumatic | | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mailir | g Address (Street a | | | City or Town, State, | Zip Code) | | | | | | |
| Ξ | and 2 | | Wayne L. Godwin (son) | 502 | St. Micl | hael Driv | e Middl | etown, DE | 19709 | | | | | | |
| ore | es 1 a of He fitem | | 20a. Method of Disposition 20b 1X Burial 2 ☐ Cremation 3 ☐ Removal from State | . Place of Dispo cemetery, crer | sition (Name of natory or other plac | e) | Date 2 | 0c. Location - City of | or Town, State | | | | | | |
| Ĕ | Pag ment ant: I | | 4 Donation 5 Other (Specify) | 11 Sain | ts Cemete | ery Aug. | 23,2008 | Wilming | ton, DE | | | | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra | | 21. Signature of Furural/Service dicensee | 788 22 | . Name and Addres | M | | uneral Ho | - | | | | | | |
| | | | 23a. Part 1. Enter the disease or complications that caused the de | ath. Do not ent | er the mode of dyin | cord Pike | or respiratory arres | DE 198 | Approximate | | | | | | |
| | Physician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition condition) | | | | | | | | | | | | |
| 1 | /Medical | | resulting in death) a. Due to (or as a conse | equence of): | 1.4101 | TAM | INAG | | - | | | | | | |
| ĝ. | Examiner | | - Prieux | DINON | () | | | | | | | | | | |
| | p # | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | equence of): | | | | | | | | | | | |
| | ecute ind trans | Examiner | that initiated events | | | | | | | | | | | | |
| 50, | oe ex | Û | Due to (or as a conse | أ المسأ | a = C : C | | | | | | | | | | |
| 68760, | tificate be executed g physician and as the bunal-transit | edical | d. HOYTIC | >TE | MOSIS | | | | | | | | | | |
| | ding se as | | IF FEMALE: 23c. If yes, outcome pf preg | inancy | | | | 004 D-1 | | | | | | | |
| Box | that the death cer ed by the attendin detached for use | Physician/M | in the past 12 months? | etal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of d Month | Day Year | | | | | | |
| o. | y the | ıysi | 1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown | douth of | other (speary) | | | | | | | | | | |
| U | Attending Physician: The law requires that the death cer croteath. erders Afth. erde | | Part II. Other significant conditions contributing to death but not re | esulting in the ur | nderlying cause give | en in Part I. | 23e. Did toba | acco use contribute | to the cause of death? | | | | | | |
| Records, P.O. | quire; n sign | q p | Old age | | | | 1 ™ Yes | 3 | Probably 4 Unknown | | | | | | |
| ပ္ပ | aw requires s been signatures should b | olete | Ambulatory Dusti | incti | DU | | 24a. Was an | | autopsy findings available | | | | | | |
| æ | Physician: The lav this certificate has al director, page 2 | Completed by | 717778(67.50) | A.1. | | | autopsy perform | ed? death? | | | | | | | |
| Vita | lan: rtifica tor, p | BeC | 25. Was case referred to medical | | | 26. Place of Deatl | 1 Yes 2 n (Check only one | | es 2 No | | | | | | |
| > | nysic nis ce direc | To B | examiner? 1 Yes 2 No Hospital: Inpatient 2 | ☐ ER/Outpatien | t 3 DOA Othe | ar. | | ice 6 DOther (Sp | pecify) | | | | | | |
| Division or | ng Pt fter th neral | | 27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injun Work | y at | 28d. Describe hov | v injury occurred | | | | | | | |
| 0 | endil eath. or: A he fu | atic | 2 Accident investigation | | | Yes 2 □ No | | | | | | | | | |
| ž | r Att ter de irect | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spec | home, farm, str | eet, factory, office | 320 | 28f. Location (Stre City or Town, | et and Number or I State) | Rural Route Number, | | | | | | |
| | urs al | | One Contifere 1 December 2 December 2 | manufacture to the | | - determined | | | | | | | | | |
| | Hosp 24 ho Fune stely f | edical | 29a. Certifier (Check only (Check only one) 2 Medical Examiner: On the basis of examinary one) | nowledge, death nation and/or in | occurred at the tinvestigation, in my o | ne, date and place, pinion, death occur | and due to the car red at the time, da | use(s) and manner te and place, and d | as stated. ue to the cause(s) | | | | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Med | 29b. Signature and title of certifier | | 29c. License | e number | 29 | d. Qate signed (Mo | nth, Day, Year) | | | | | | |
| | ⊢ 3 ⊢ ŏ | | > hundred | | Da | 5090 | 01 8 | 177/1 | 8 | | | | | | |
| 7 | | | 30. Name and address of person who competed cause of death (It | em 23a) (Tyne | Print) | 00 10 | | 12210 | 0 | | | | | | |
| | 12 | | Muhammed Niaz, MD 266 S. | College | e Ave. | Newark, D | E 1971 | 1 | | | | | | | |
| Q | Sta | | 31. Date filed (Month, Day, Year) AUG 2 6 2008 32. Registrar's Sig | nature | hack : | | | | | | | | | | |
| | Registr | :12 | | A.J. As | - CO - CO | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 🕕 🗓 🖰 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** August 20, 2008 8:10 A. M Helen Jones Gorrell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 08-09-1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 TF Ohio 88 579-12-1666 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location wode 10a. State 10d. Inside City Limits 27 is marked other than "naturel" or items 23a or 28a-f show traumatic event, the Medical Examinar count to notified at 1 ☐ Yes 2 😾 No Director MD Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20657 12998 Holly Way United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: if item 27 is marked other than "nateny injury or other traumatic event, the Macian page. Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrator Treasury Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Franklin Jones Peggy Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grier G. Smokovich (Daughter) 1846 Leslie Road, Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory 8/21/08 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequé ice of): Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and deteched for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → X No 24a. Was an Was autopsy performed? has certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1.2 Certifying Physician: To the best of my knowledge, ceath ordinard at the time date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67594 30,3008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hon Lepp 31. Date Hed (Month, Day, Year) 100 Hepital Park Prince Frederick, MD

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Bren H. Sparke

| | | 1 | _ State | ate of Marylan | | artment of F rtificate of I | | | - | 2002 | 20702 |
|--|----------------|------|--|--|-----------------------|--|----------------------|----------------------------------|--------------------------|-----------------------------------|--|
| ¥ | | | 1. Decedent's Name (First, Middle, Last) | | - 007 | tillicate of i | Death | 2. Date of De | Reg. No./ | 000 | 3. Time of Death |
| Physi | ician dical | | WILLIAM H. GREEN | J | | | | 08-20-2 | | Year | 12:15 A ^M |
| Exam | niner | ı | 4a. Facility Name (If not institution, give stree | ŕ | | | r Location of Death | | | County of Death | |
| A residence | | 4 | 1421 SOUTHERN AVENUE 5. Social Security Number 6. Sex | APT. 203 | last hirthday) | Oxon Hi | | 8. Date of Birt | | nce Geo: | rge s place (State or Foreign |
| Funera Directo | | | 231 - 68-0819 | | Yrs. | Months Days | Hours Min. | (Month, Da 01-28-1 | y, Year) 948 | Virg | ntrv) |
| and w | | - 1- | Usual Residence of Decedent 10a. State 10b. County | 10c, Cit | ty, Town or Lo | ocation | | | | 1 | 10d, Inside City Limits |
| Maryl f sho | ē | 5 | Maryland Prince Georg | re's | Ox | on Hill | | | | | 1 ∰Yes 2 □ No |
| r 28a | Directo | 3 | 10e. Street and Number | 50 0 | OA | 10f. Zip Code | | | 10g. Citiz | en of What Cou | ntry? |
| h with | a D | 1 | 1421 Southern Avenue | e Apt. 203 | | 20745 | | | U | SA | |
| deat | Funeral | | 11 Marital Status 12. V | Vas Decedent Ever in U | .S. 13. | Was Decedent of H If Yes, specify Cuba | lispanic Origin? (Sp | pecify Yes or No Bican, etc.) | - 1 | 4. Race - Americ Black, White, | |
| aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notifiled at | 2 | 2 | 1 ☐ Never Married 2 Married 1 | Yes 2 No Yes, Give ear or Dates: 12−1 | | 1 □ Yes 24⊟XNo | Specify: | , mount over | | Casalé | ack |
| 21215-0036 d within 72 hours af giene. rr than "natural", or the Medical Examili | Completed | | 15. Decedent's Educatio (Specify only highest grade cor | n | 16a. Dece | dent's Usual Occup | ation | kina | 16b. Kin | d of Business/In | |
| 215 Ithin 7 Ithin 7 Ithin 7 | l se | - | | College (1-4or 5+) | life. | DO NOT use retired | d) - | | | | |
| d 21 filled wi Hygier ther th | | | | HO2 | Feder | al Protec | | | | ral Gov | ernment |
| Maryland 2 d 2 should be filed th and Mental Hygi 27 Is marked other traumatic event, t | a | í | 17. Father's Name (First, Middle, Last) David Green | | | | 18. Mother's Nam | e (First, Middle, Friend | Maiden S | Surname) | |
| hould Me mark | P | - | 19a. Informant's Name/Relationship (Type. F | Print) | 19h Mailir | ng Address (Street | | | er City or | Town State 7in | 2 Code) |
| Ma a strain | | | Donna Green/wife | , | | Southern | | | | 1.MD 20 | ′ |
| s 1 and 3 f Health litem 27 other tra | | 1 | 20a. Method of Disposition | | Place of Dispo | osition (Name of | 20) | Date | | ation - City or T | |
| altimore, mit. Pages 1 ar partment of Hea portant: If Item ? | | | 1 Barial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify) | val from State Mar | yland | Vet. Ceme | tery 08-28 | 8-2008 | Chel | tenham, | Maryland |
| Baltimor permit. Pages Department of Important: If It any injury or or | nce. | Ī | 21. Signature of Funeral Service Licensee | MO124 | 6 2 | 2. Name and Addre | ss of Facility | | α . | . 1 1 M | D 20776 |
| | Oi . | + | 222 Part 1 Enter the disease or complication | uns that caused the deat | | edar Hill | | | | tland,M | D 20746 Approximate |
| | | ļ | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final | | | | | | | | Interval Between Onset and Death |
| Physiciai /Medica | _ | | disease or condition resulting in death) | alignant ne | | bronchu | is and Lui | ng,unspe | ecfie | ed | |
| Examine | r | | | Due to (or as a conseq | quence oi). | | | | | | |
| | je je | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or se a consec | uance or; | | | | | 132 | |
| scuted nd transi | Examiner | | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 58760, icate be executed physician and s the burial-transit | | | resulting in death) Last | Due to (or as a conseq | quence of): | | | | | | |
| | edical | | d | | | | | | | | |
| death certifi death certifi e attending | Physician/Me | | | yes, outcome pf pregn | | Je | | | 2 | 3d. Date of deliv | rery |
| _ 0 0 0 | icia | | in the past 12 months? 1 ☐ Yes 2 ☐ No | □Live birth 2□Feta □Pregnant at time of c □Unknown | | □Ectopic pregnancy □ Other <i>(specify)</i> | / | | | Month | Day Year |
| Hecords, P.O. The law requires that the de tte has been signed by the ℓ bage 2 should be detached | hys | - | 9 Li Unknown | | | | | T | | | |
| IS, F | Ş | | Part II. Other significant conditions contribu | iting to death but not res | sulting in the u | nderlying cause giv | en in Part I. | | | | the cause of death? |
| COLD w require been sig should b | ted | | | | | | | '' | res 216 | No 3 Pro | bably 4 Unknown |
| Hecords, The law requires the has been signed age 2 should be considered. | Completed | | | | | | | 24a. Was | | | opsy findings available ompletion of cause of |
| | | | Of Was seen referred to modified | | | | | 1□ Yes | 2 No | | 2 No |
| Or VITAL Physician: This certificat ral director, pa | o Be | l l | 25. Was case referred to medical examiner? 1 ☐ Yes 2FTNo Hosp | tal: 1 ☐ Inpatient 2 ☐ |] ER/Outpatier | ot all DOA Oth | er: | | | □Other (Speci | |
| g Phys er this eral dir | - | 16 | 27. Manner of Death 2 | Ba. Date of Injury | 28b. Time o | | | 28d. Describe | | | 1 <u>y)</u> |
| ION ath. rr: Aft | atio | | 19⊡Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | | K? Yes 2 □ No | | | | |
| DIVISION OF I or Attending Phy after death. I Director: After this d in by the funeral di | Certification: | | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2: | Be. Place of injury - At h building, etc. (Speci | ome, farm, sti fy) | reet, factory, office | | 28f. Location (| Street and wn, State) | Number or Run | al Route Number, |
| Ital o | | | | | | | | | | | |
| DIVISION O To the Hospital or Attending PI within 24 hours after death. To the Funeral Director; After it completely filled in by the funera | edical | 3 | 29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner: | | | | | | | | |
| To the within To the | Me | | 29b. Signature and title of certifier | | | 29c. Licens | e number | | 29d. Date | e signed (Month, | Day, Year) |
| 10 | | | Marstans Co |) | | 1466 | 665 | | 08-2 | 20-2008 | |
| 2 (6) | | - 1 | 30. Name and address of person who comple Dona Leskuski, 920 | eted cause of death (Iter O Basil Cou | | Print) O Largo. | , Marylan | d 20774 | | | |
| 75 | State | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ature | | | | | | |
| Regis | strar | | MOU 2 0 2000 | and It is | grave) | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Jerry Dale Hart 11:35P M September 2008 1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 7131 Dam Number Four Road Sharpsburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 217-84-8729 46 Yrs June 24, 1962 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Washington Sharpsburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21782 7131 Dam # 4 Road U.S.A. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □ Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Trucking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Z. Roane Judith A. Stouffer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracey D. Bowman (Sister) 15910 Cheneys Neck Ln. Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State September Smithsburg, Maryland 4 Donation 5 Dother (Specify) Smithsburg Crematory 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 | 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eour disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an,

State Registrar

31. Date filed (Mg

M

2. Registrar's Signature

| | | | State of Marylar | | | | | 0000 | 2070! |
|--------------------|---|----------------|--|----------------------------------|--|---|---------------------------------|-------------------------------------|--|
| | _ | | 1 - State Registrar 1. Decedent's Name (First, Middle, Last) | Cer | tificate of l | Death | 2. Date of Deat | eg. No.2008 h | 28704 3. Time of Death |
| į. | Physicia /Medic | | • | ardin | g | | Month | 31 ⁷ / 2008 | 6:55 A M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) Gilchrist Center | | 4b. City, Town, or Towso | Location of Death | | 4c. County of Dear Baltin | |
| | Funeral | | 5 Social Socurity Number 6 Soy 7 Ago (In ure | . last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Bir | thplace (State or Foreign |
| L | Director | | 212-30-8986 1 M 2 F 74 | Yrs. | Months Days | Hours Min. | 7/14/1 | .934 Mai | yland |
| | land bw t | | Usual Residence of Decedent 10a. State 10b. County 10c. C | ity, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Mary a-f sho | tor | Md. Harford | White | ford | | | | 1 □Yes 2 No |
| | or 28 | Director | 10e. Street and Number | | 10f. Zip Code | | 1 | 0g. Citizen of What Co | ountry? |
| | eath w | Funeral | 1542 Main Street 11. Marital Status 12. Was Decedent Ever in U | I.S. 13.1 | 211 | | ecify Yes or No- | 14. Race - Ame | erican Indian, |
| 336 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by | Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | f Yes, specify Cuba 1 ☐ Yes 🍱 No | lispanic Origin? (Sp an, Mexican, Puerto Specify: | Rican, etc.) | Black, Whit | vhite |
| 5-0036 | 72 ho natur | eted | 15. Decedent's Education (Specify only highest grade completed) | (Give | dent's Usual Occup | during most of work | ing | 16b. Kind of Business | /Industry |
| 121 | within ene. than " | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | life. L | OO NOT use retired Caregi | * | | Nursin | g |
| מ | al Hygi other vent, t | Be Co | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | e (First, Middle, I | Maiden Surname) | |
| ylar | ould by Menta arked atic ev | ToE | William Henry Moudry | | | Hele | | | naggio |
| Maryland 21 | nd 2 shulth and 27 is m | | 19a. Informant's Name/Relationship (Type. Print) Richard E. Harding | | - | and Number or Rur St. Whi | | , City or Town, State, Md. 2. | Zip Code) L160 |
| Baltimore, | es 1 al of Hea fitem rothe | | 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State | Place of Dispo cemetery, crer | sition (Name of matory or other place | | Date | 20c. Location - City or | Town, State |
| <u>ti</u> | E Pag tment tant: i | | 4 □ Donation 5 □ Other (Specify) | | w Mem. | | 03/08 | Fallsto | , |
| Ba | permit Depar Impor any in | | 21. Signature of Funeral Service Licensee Benjamen W. Kuitz | Н | ome, P. | A. Jar | rettsv | tz & Son ille, Ma | ryland |
| ı | | | 23a. Part1. Enter the disease, or compressions that caused the dea shock, or heart failure. List only one cause on each line. | | er the mode of dyir | ng, such as cardiac | or respiratory arr | est, | Approximate Interval Between Onset and Death |
|) | Physician /Medical | | Immediate Căuse (Final disease or condition resulting in death) Due to (or as a conse | | | | | | months |
| 1 | Examiner | | | | | | | | |
| | ted nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | quence of): | | | | | |
| o, | execu in and ial-tra | Exar | that initiated events resulting in death) Last c Due to (or as a conse | equence of): | | | | | |
| 8760 | icate be executed physician and s the burial-transit | dical | d | | | | | | |
| 9 | | /Mec | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf preg | nancy | | | | 23d. Date of de | livery |
| .O. Box | The law requires that the death certifi ate has been signed by the attending I bage 2 should be detached for use as | Physician/Me | in the past 12 months? 1 Yes 2 No 9 Unknown | | Ectopic pregnanc Other (specify) | у | | Month | Day Year |
| Vital Records, P.O | quires that n signed b | b | Part II. Other significant conditions contributing to death but not re Caron my Atay disease, di | | | | 23e. Did to | bacco use contribute es 2 No 3 F | to the cause of death? Probably 4 Unknown |
| Reco | he law re has bee ge 2 shoi | Completed | Obstrative leng disease | , His | try of | | 24a. Was a autop perfor | sy prior to med2 death? | |
| ta | ian: T rtificate tor, pa | Be Co | 25. Was case referred to medical | | | 26. Place of Dea | | 2 I No 1 □ Ye | s 2□No |
| ۲ > | hysici this ce | To B | | ☐ ER/Outpatier | | 4 LI Nursing H | | lence 6 Sother (Sp | ecity) Hospice |
| ono | ding F th. After funera | tion: | 27. Manne-of Death 1 | 28b. Time o Injury | Wo | ryat rk? ∣Yes 2 ∐ No | 28d. Describe h | ow injury occurred | |
| Division or | i or Attendafter death Director: | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Special Could not be determined building, etc. (Special Could not be building). | home, farm, str cify) | | | 28f. Location (S City or Tow | treet and Number or F vn, State) | Rural Route Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: | | 29a. Certifier 1 ☐ Certifying Physician: To the best of my k (Check only 2 ☐ Medical Examiner: On the basis of exami | nowledge, deat | h occurred at the ti | ime, date and place | , and due to the or | cause(s) and manner a | as stated. |
| | o the lithin 24 or the Formplete | Medical | one) and manner stated. 29b. Signature and title of certifier | | 29c. Licens | | | 29d. Date signed (Mor | |
|) | F 3 F 8 | | 1 1 1 1 4 | no | 02 | 5205 | | | er 2,2008 |
| • | | | 30. Name and address of person who completed cause of death (It | em 23a) (Type, | Print) | 5205 . Balt. | M -1 3 | 7.1200 | |
| | Sta | at o | 31. Date filed (Month, Day, Year) 32. Registrar's Sig | | ecces 11 | , 1) 000. | / // 4 2 | | |
| | عادي Registi | | SEP 0 8 2008 | No. | heed 5 | | | | |

| | | | For | State | of Marylan | | ertment of I | | d Mer | | 2.0 | 008 | 28705 |
|-------------|--|----------------|---|--|--|---------------------------------|---|--|-------------|----------------------------------|-------------------------------|---------------------------------------|---|
| | | | Registrar 1. Decedent's Name (First, Middle | , Last) | | | inicate of | Dealii | 2. | Date of Death | g. No. 🚄 🕻 | 000 | 3. Time of Death |
| | Physicia | | Kevin Antho | | - | | | | | Month | Day | Year | 09:10 PM |
| 4 | /Medic Examin | | 4a. Facility Name (If not institution | | | | 4b. City, Town, | or Location of De | | igust | 24 4c. Count | 2008 by of Death | 1 09:10 PM |
| | 4 | | 49 Sparkler La | ne | | | North | East | | | Cec | i 1 | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. I | | If Under 1 Year Months Days | If Under 24 H | Hrs. 8. | Date of Birth (Month, Day, | | | lace (State or Foreign |
| | Director | | 054-48-5832 | X XM 2□ F | 53 | Yrs. | | | | ov. 9, | 1954 | | York |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| | f sho | ō | New York Su | llivan | 1.71_ 3 | T -1 | | | | | | | 1 ∐ Yes ZANo |
| | death with the Maryland ms 23a or 28a-f show must be notified at | Director | 10e. Street and Number | LIIVali | WILL | te Lal | 10f. Zip Code | | | 10 | g. Citizen of | What Coun | itry? |
| | h with | a D | 2639 Route 55 N | √est | | | 1278 | 5 | | τ | nited | State | es |
| | ems a | Funeral | 11. Marital Status | 12. Was Dec | cedent Ever in U. | S. 13.\ | Was Decedent of f Yes, specify Cul | Hispanic Origin? | ? (Specify | Yes or No- | | ace - Americ | |
| ٥ | be filed within 72 hours after death with the Marylar tal Hygiene. did other than "natural", or frems 23a or 28a-f show event, the Medical Examiner must be notified at | | 1 XNever Married 2 Marr | ied 1 □ Yes If Yes, G | 2 [X [X 0 | | 1 □ Yes 2 🕅 No | | | a., c.o., | Spec | | |
| 9-00-6 | hours ural"; | d by | 3 Widowed 4 Divorced | Year or I | Dates: | | | | | | | | |
| 7 | within 72 ene. than "nal he Medica | Completed | 15. Decedent (Specify only highes | st grade completed, | | (Give | dent's Usual Occu kind of work done DO NOT use retire | during most of t | working | | 6b. Kind of I | business/inc | dustry |
| 717 | iene. iene. r thar the M | шо | Elementary/Secondary (0-12) | College 4 | (1-4or 5+) | | or Info | , | Techr | 1010gv | R | etail | |
| and. | al Hygie other vent, th | a) | 17. Father's Name (First, Middle, | Last) | | | | 18. Mother's h | | | | | |
| ē | | To B | James Edward H | laynes | | | | Cath | nerin | ne Verd | nica (| Cavana | ugh |
| Mar | s 1 and 2 should if Health and Mer Item 27 is marke other traumatio | | 19a. Informant's Name/Relations Michelle J. Holr | | | | ng Address (Stree | | | , | , | | 1.11.17 |
| | s 1 and s f Health Item 27 other tr | | | les / Com | - | | Sparkler | | | | | | 21901 |
| altimore, | Pages 'nent of H | | 20a. Method of Disposition 1X Burial 2 ☐ Cremation | | i State | | sition (Name of natory or other pla | | ıgust | | 20c. Location | • | , |
| | permit. Pages Department of Important: If I any Injury or once. | | 4 □ Donation 5 □ Other (S | | Eve | | Cemete: Name and Addr | | 6, 20 | | | - | lew York |
| n m | Department once | | 1/1/1/4/4/ | | | I | | | | | | | y1and21901 |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that | caused the death | | | ng, such as care | rdiac or re | espiratory arre | | | Approximate Interval Between |
| | Physician | 10 | Immediate Cause (Final disease or condition | Only one cause on | -5DD | na | w X | (a | - | een | | _ | Onset and Death |
| j | /Medical | | resulting in death) | a. Due to | o (or as a consequ | uence of): | | | | | | | & monto |
| | Examiner | , | Sequentially list conditions. | b | | | | | | | | | |
| 2. | pa tis | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | o (or as a consequ | uence of): | | | | | | | |
| 9 | xecut and II-tran | Examiner | that initiated events resulting in death) Last | c | o (or as a consequ | uence of): | | | | | | | |
| 8/60 | ificate be executed g physician and is the burial-transit | dical E | | | , | | | | | | | | |
| 20 | death certificate be executed e attending physician and d for use as the burial-transit | edic | | d | | | | | | | | | |
| X Q Q | leath certific attending p I for use as | N/UE | IF FEMALE: 23b. Was decedent pregnant | | utcome pf pregna | | ⊒Ectopic pregnan | 014 | | | 23d. E | ate of delive | ery |
| - | ed for | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No | | gnant at time of d | | Other (specify) | Су | | | Α. | Month | Day Year |
| r Ö | at the d by the etached | Phy | 9 Unknown | | | | - d - d d | in a la Banki | | 00- Did t-b | | -4-114411 | |
| Š, | w requires that the d been signed by the should be detached | þ | Part II. Other significant condition | wis contributing to | death but not rest | ulang in the u | ndenying cause g | iven in Part I. | | 23e. Did löt. | | | he cause of death? |
| cord | v requ | etec | | | | | | | - | | | | |
| ĕ | sician: The law certificate has b irector, page 2 st | Completed | | | | | | | - | 24a. Was ar autops perforn | v | o. Were auto prior to co death? | ppsy findings available mpletion of cause of |
| <u>0</u> | in: Ti ificate or, pa | ပ္ပို့ | 25. Was case referred to medica | | | | | 00 81 | | 1□ Yes 2 | No. | 1 ☐ Yes | No |
| 5 | Physician: this certific al director, | o Be | examiner? | Hospital: | Inpatient 2 □ | ER/Outpatier | nt 3 DOA O | ther: | | theck only one 5 ☐ Reside | | thor /Cnocif | 5-1 |
| יסר | | - | 27. Manner of Death | 28a. Date | e of Injury onth, Day Year) | 28b. Time o | | | | I. Describe ho | | - | y/ |
| <u>0</u> | Attending r death. ector: Afte by the fune | atio | 1 Natural 5 Pendin 2 Accident investig | gation | inii, Day real/ | injury | | Yes 2 No | | | | | |
| UNISION | or Att ter de lirect | Certification: | 3 Suicide 6 Could determ | inod 28e. Plac | ce of injury - At ho ding, etc. (Specif | ome, farm, str | eet, factory, office | | 28f. | Location (St. City or Town | reet and Nur. , State) | nber or Rura | al Route Number, |
| | pital c | | 200 Cortifica 4 No- | Dhustain T :: | he boot of v | uuloal = - t : t | h coordinate to the | Almon de la companya de la companya de la companya de la companya de la companya de la companya de la companya | | cault o | | | |
| | e Hos 24 ho e Fune letely f | Medical | 29a. Certifier 1 Certifyir (Check only one) 2 Medical | ng Physician: To the Examiner: On the and ma | ne best of my kno basis of examina inner stated. | wiedge, deat ition and/or in | n occurred at the vestigation, in my | time, date and p opinion, death o | occurred | at the time, d | ause(s) and i ate and plac | manner as s e, and due t | otated. o the cause(s) |
| | To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Me | 29b. Signature and title of certifie | 2 | | 14 | 29c. Licer | nse number | | 2 | 9d. Date sign | ned (Month, | Day, Year) |
| | | | 200 | <u> </u> | | 1-9 | 7 0 | D056 | 040 | 17 | 80 | 5/0 | 26 |
| | | | 30-Name and address of person | - iAA | use of death (Item | 1 23a) (Type | Print) | 15. | to | 200 | FIL. | LL | 17 21001 |
| | /0 Sta | te | 31. Date filed (Month, Day, Year) | 32 | gistrar's Signa | iture, | 11.4. | 1. 000 | 12 | ~~ | UIII | 301 | 001701 |
| | Registr | | AUG 2 | 6 2008 | Gerene. | D. 14 | DEVEL | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** AUGUST PM ROBERT LLOYD JENKINS, SR. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHAR NISTA MEDICAL ATA If Under 24 Hrs. ENTER f Under 1 Year 8. Date of Birth (Month, Day, Year) 8 – 9 – 1925 9. Birthplace Country) Social Security Number 7. Age (In yrs. last birthday (State or Foreign Funeral Days Hours Months 1 □ M 2 □ F PĂ. 211-12-5497 83 Director Usual Residence of Decedent 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner inset be notified at MD. CHARLES 1 ☐ Yes 2 X No WALDORF Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4321 HUMBOLT COURT 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. I limportant: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Exemptemone. Black, White, etc. 1 ☑ Yes 2 □ No NAVY If Yes, Give Year or Dates: WWII 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. ģ Specify: WHITE 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ANDREWS AFB Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT.. COMMISARY GROCERY MGR. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EUGENE JENKINS RUTH CUSTER ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4321 HUMBOLT CT. WALDORF, MD. 20601 NORMA JENKINS-SPOUSE 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 9-2-08ALEX., VA. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee M00479 LA PLATA, MD. 20646 (uchore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HRON Immediate Cause (Final phocytic LukemiA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> DEMENTA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HERES ZOSTER 1 ☐ Yes No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 pnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HEN DING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 102 PAULMELION CT, WALPORF MD 20602 SHVINKUMAR 3. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 08

OH! DI

| | | 1 - For State Registrar | State of Mar | | partment of H ertificate of L | | | leg. No. 2 | 28707 | | |
|---|-------------------------------------|---|--|-----------------------------------|---|---|--|--|---|--|--|
| Physicia /Medic | | 1. Decedent's Name (First, Middle, La | | Jane Kerl | lin | | 2. Date of Dea Month AV9US7 | th Day Year | 3. Time of Death 9 0 9/0/4 M | | |
| Examin | | 4a. Facility Name (If not institution, give | e street and number) | | 4b. City, Town, or | Location of Deatl | n | 4c. County of Dea | | | |
| | | Washington County | | | | agerstow. | | | ington | | |
| Funeral Director | | 217-20-7150 | M 2 F | (In yrs. last birthda 75 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day March 1 | (, Year) C | thplace (State or Foreign ountry) Maryland | | |
| perfinit. Fages I and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Madical Examination in other traumatic event, If a Madical Examination in other traumatic event, If a Madical Examination in other traumatic event, If a Madical Examination in other traumatic event, If a Madical Examination in other traumatic event, If a Madical Examination in other events. | To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State 10b. County Maryland Washi | Ington | loc. City, Town or | | rstown | | FAP-16 | 10d. Inside City Limits 1√2 Yes 2 □ No | | |
| | | 10e. Street and Number 310 North Mulberry St. | | | 10f. Zip Code | 10f. Zip Code 21740 | | | ountry? | | |
| | | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent Event Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates: | er in U.S. | I 3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No | ispanic Origin? (S in, Mexican, Puerl Specify: | pecify Yes or No- o Rican, etc.) | Specify | | | |
| in "natura Medical E | | 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | ducation ade completed) College (1-4or 5+) | (Gi | cedent's Usual Occup ve kind of work done o b. DO NOT use retired | during most of wor | rking | 16b. Kind of Business | | | |
| giene er tha | | 8 | Oollege (1-40/ 54) | | Homemake: | r | | Home | | | |
| lental Hy ked oth | | 17. Father's Name (First, Middle, Last) Charles E. Wilson | | | | 18. Mother's Name (First, Middle, Vernie Ro | | | | | |
| and M mar umat | | 19a. Informant's Name/Relationship | (Type. Print) | 19b. Ma | illing Address (Street | and Number or Ri | ıral Route Numbe | r, City or Town, State, | Zip Code) | | |
| armit. Pages 1 and 2 epartment of Health apportant: If item 27 is ny injury or other tra 100. | | Charles E. Class 20a. Method of Disposition 1□Burial 2☑Cremation 3□ | Removal from State | 20b. Place of Dis cemetery, co | position (Name of rematory or other place | Sep | Date tember | 20c. Location - City o | | | |
| | | 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice | nsee | | irg Cremato 22. Name and Addres | ss of Facility | | is Funeral | | | |
| 10 E E 9 | < | Mol4/4 12525 Bradbury Ave. Smithsburg, Maryland 21783 | | | | | | | | | |
| hysician /Medical | cal Examiner | 25a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a. Acut | Rem | enter the mode of dyin | | c or respiratory an | rest, | Approximate Interval Between Onset and Death | | |
| xaminer | | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | b. Kep. | consequence of): | - synd | Long | | - | 2000 | | |
| ysician and e burial-transit | | Cause (Disease or injury that initiated events resulting in death) Last | c. Push Due to (or as a | consequence of): | utori; | y Liv | <u>~</u> | | to main | | |
| as th | Medi | | | | | | | | | | |
| y the attendir | Be Completed by Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown | Fetal death | 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _ | у | | 23d. Date of do Month | elivery Day Year | | |
| signed by | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I | | | en in Part I. | rt I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown | | | | | |
| page 2 shou | | Doren Cage | | 2 onto | . , | man | | sy prior to med? death? | autopsy findings available completion of cause of | | |
| To the hospital of Attenuing Frigstrati. The law requires that the obtain certificate within 24 hours after a from the formation of the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I | | 25. Was case referred to medical examiner? | | | | | ath (Check only or | ne) | | | |
| | n: To | 1 Yes 2 LHO 27. Manner of Death | 28a. Date of Injury | | of 28c. Injur | 4 LI Nursing F | | dence 6 Other (Sp | ecify) | | |
| | ertification: To | 1 ☐Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined vertically a continuous formula in the determined building, etc. (Specify) | | | M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location | | | (Street and Number or Rural Route Number, own, State) | | | |
| | Medical Ce | 29a. Certifier (Check only one) 1 Gettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 24 hou Funer etely fill | | 29b. Signature and title of certifier | | | 29c. License number D (8 ° (9 | | | 29d. Date signed (Month, Day, Year) AVC 31, 2008 | | | |
| within 24 hour Volume Funer completely fill | Med | | 20 | | D 18 | 0 (9 | | AV 2 31, 2 | 800 | | |
| within 24 hour replacement of the Funer completely fill | Med | | completed cause of dea | | e, Print) | | | ow~ ~ | | | |

State of Maryland / Department of Health and Mental Hygiene, 28708 For State Registra Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 19, 2008 Year **Physician** 5:42 p. м John Edward Kawecki /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick FRederick Homewood at Crumland Farms If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 85 Yrs. 1923 Apr 26, Connecticut **Director** 046-18-7732 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 🏋 No Maryland Frederick Frederick Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7400 Willow Road 21702 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No white þ 1942 3 Widowed 4 □ Divorced Completed 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) engineer telecommunications 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth eny linury or other treumatic event spice. 17. Father's Name (First, Middle, Last) Alexandra Sienko John Kawecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4822 Ed McClain Road, Monrovia, Maryland 21770 Carolyn Kawecki - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Catholic 8-25-2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 unill Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 1800 /Medical Due to (or as a do Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Box 68760 Physician/Medica IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an partormed? 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death |Check only one| Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification; To Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Matural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after. 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of entifier 29c. License number 00145 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West Ninth Street, Frederick, Maryland Casper Cline, M.D. 31. Date filed (Month, Day, Year) 2 2 2008 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 17, 2008 **Physician** AUGUST BARBARA В. KELLY 11:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 21 Harvard Court Rockville MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Days Months 72 Yrs. Director Feb.19 ,1936 517-46-9780 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified at Completed by Funeral Director MD 1√2Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21 Harvard Court 20850 items 23a U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status traumatic event, the Medical Expr. in art. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, If a Maria once. (Give kind of work done during most of working life. DO NOT use retired) D.C. Public Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Brock Emma Stannard 19a. Informant's Name/Relationship (Type. Print (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence R. Kelly, Jr 21 Harvard Court, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem 8/22/08 Silver Spring,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Ligensee 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart milure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure wks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Restrictive Lung Disease Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 Yr Examiner Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Neuromuscular Weakness 1 Yr Due to (or as a consequence of) Box 68760. Physician/Medical Amytrophic Lateral Sclerosis 1 Yr IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. □Yes 2 No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/19/08 D36252 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10605 Concord St, Ste 500, Kensington, MD Steven T. Kariya, M.D. 31. Date filed (Month, Day, Year) AUG 2 2 2008 32. Registrar's Signature Registrar Messes.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06399 State of Maryland / Department of Health and Mental Hygiene Javne Lorell Leonard 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 21, 2008 Jayne Lorell Leonard Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cecil Port Deposit 835 Craigtown Road 8: Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Maryland Country Months Days Hours Min Director 1937 Oct. 30, 220-32-3529 70 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show or items 23a or 28a-f shormust be notified at once. Cecil Conowingo Maryland with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21918 1530 Dr. Jack Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? death Never Married 2 Married 2 X No Yes White Specify: Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after 3 X Widowed If Yes, Give Yea 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 27 is marked other than Baltimore, MD 21215-0036 event, the Medical Personal Residence Twelve Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Thomas Edward C. Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health and Me Important: If item 27 is ma injury or other traumatic ea 835 Craigtown Road, Port Deposit, Maryland 21904 Lee Bailey (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State X Burial 2 08/27/08 Port Deposit, Maryland Asbury Cemetery Other Specify Donation 5 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, 21 ignature of Funeral Service Licenses 21903-0766 Perryville, Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical a Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED attending physician or use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: signed by the a δ

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Completed certificate has be ector, page 2 sh Be After this c funeral dire ٩ Medical Certification: within 24 hours after death.

To the Funeral Director: Director: d in by the f 29b. Signature and title of certifier

| Van 2 a No 0 Halmann | 1 Live birth 4 Pregnant at time of de 9 Unknown | 2 Fetal dea | | nancy | Month | Day | Year |
|---|--|---|--|---|----------------|--|---|
| Part II. Other significant conditions | ontributing to death but not r | esulting in the underly | ing cause given in Part I. | | | ntribute to the cau | |
| | | | | 24a. Was ar autops perforn 1 Yes 2 | y ned? | . Were autopsy f prior to complet death? 1 Yes | indings available tion of cause of 2 No |
| 25. Was case referred to medical | | | 26.Place of Death (Chec | k only one) | | | |
| | spital: 1 Inpatient 2 | ER/Outpatient 3 | DOA Other Nurs | sing Home 5 F | Residence 6 | ✔ Other: Scen | е |
| 7. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury FOUND: Aug 21, 2008 | 28b. Time of Injury FOUND: 1225 hrs | 28c. Injury at Work? 1 Yes 2 ✓ No | 28d. Describe ho Subject fell | ow injury occi | urred | |
| 2 V Accident Investigation 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h | ome, farm, street, fact | ory, office building, etc. | 28f. Location (St or Town, St 1530 Dr. Jack | ate) | | ute Number, City |
| 29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: 0 | a: To the best of my knowled in the basis of examination a and manner stated. | ige, death occurred at and/or investigation, in | the time, date and place, ar my opinion, death occurred | nd due to the cause d at the time, date a | (s) and manr | ner as stated. d due to the caus | e(s) |
| 29h Signature and title of certifier | The state of the s | | 29c. License number | a 100 | 29d. Date si | gned (Month, Da | ay, Year) |

OCME

111 Penn Street, Baltimore, MD 21201

August 22, 2008

O.C.M.E.

1235 hrs

Yes 2 x No

Approximate Interval Between Onset and

Death

31. Date filed (Month, Day, Ygar) 6 State 2008 Registra

Theodore M. King, Jr., MD.

and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

College

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** September 2008 0417 Ralph E. Moore, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 602 Lewisville Road Ceci1 E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Days 1**X** M 2□ F Director 222-20-0902 76 March 20, 1932 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director Ceci1 E1kton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Lewisville Road 21921 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 2000. 12. Was Decedent Ever in U.S. Armed Forces? 1952-14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 M Yes 2 No 1952 If Yes, Give 1954 Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph E. Moore, Sr. Leeola Pugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reba E. Moore/Wife 602 Lewisville Road, Elkton, MD20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5, 2008 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill, MD 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a CANCER OF COLON WITH IN ETASTASES YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an ospital or Attending Physician: Thours after death.
uneral Director: After this certificate ly filled in by the funeral director, pa 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar emed,

Rolando A. Najera,
31. Date filed (Month, Day, Year)
SEP 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D., 138 Cathedral Street, Elkton, MD

000746

9-3-08

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

6 Sev

1 □ M 2 1 F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

McHugh

7. Age (In yrs. last birthday,

77

Certificate of Death

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

August 18, 2008 Year

2. Date of Death

20:40

Birthplace (State or Foreign
Country)

Physician /Medical **Examiner**

Funeral

Physician: The law requires that the death certificate be executed nding physician and Box 68760, P.O. Division of Vital Records,

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year) | Teb 6, 1931 Maryland 220-56-2831 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exemple must be notified at Silver Spring 1XIYes 2 □ No Maryland Maryland Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 901 Arcola Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No white Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home th and Mental Hygie 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Poole William Burdette ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau 21788 14105 Graceham Road, Thurmont, Maryland David Savage - son 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stauffer Crematory 8-21-2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee due 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYPOXIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL FATLURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): END STAGE EMPHY SEM ! Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 2 Mo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown SEPSIS URINARY 24b. Were autopsy findings available prior to completion of cause of death? TRAC 24a. Was an 2 No 2 110 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of I or Attending P after death. 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending ours after death.

neral Director; Af

filled in by the fu 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59121 19/2003 T. MALIK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM PARIC 20912 7600 CARROLL AVENUE TAKOMA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| | For State Certificate of Death | Reg. No. a of Death 3. Time of Death | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician/ edical Examiner | | e of Death nth Day Year gust 30, 2008 3. Time of Death 0753 hrs | | | | | | |
| | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5990 River Road Bryans Road | 4c. County of Death Charles | | | | | | |
| I dilicial | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. D | ate of Birth(MM/DD/YYYY) 9. Birthplace (State or Ct. 29, 1975 | | | | | | |
| any. | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits 1 Yes 2 X No | | | | | | |
| the Maryland a or 28a-f show tiffied at once. Director | Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code | 10g. Citizen of What Country? | | | | | | |
| rith the Miss or 2 and 12 and 15 and | 5960 River Road 20616 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican | Mexico Yes or No- 14. Race - American Indian, Black, white, etc. | | | | | | |
| fier death with 1", or items 23 er must be no | Armed Forces? Armed Forces? Yes 2 X No | n Specify: Hispanic | | | | | | |
| n "natural" al Examine | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Laborer | lone 16b. Kind of Business/Industry Landscaping | | | | | | |
| 5-0036 led within 72 hour. Hygiene. other than "natu the Medical Exan Completed | 17. Father's Name (First, Middle, Last) | t, Middle, Maiden Surname) | | | | | | |
| e, MD 21215-0036 t and 2 should be filed within 72 hours after death with the Maryland Health and Meintal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show reanimatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | Juan Inocecio Paniagua Juana Me 19a. Informant's Name/Relationship (Type, Print) John Denison/Employer 19b. Mailing Address (Street and Number or Rural 8911 Oxon Hill Rd. Ft. | Route Number, City or Town, State, Zip Code) | | | | | | |
| _ s 4 = 0 | 20a. Method of Disposition 1 Burial 2 Cremation 3 X Removal from State Panteon Municipal de 9/5/200 | te 20c. Location - City or Town, State | | | | | | |
| Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr | 4 Donation 5 Other Specify: Acambaro 21 Sign for of Funeral Service Licensee 22. Name and Address of Facility Georg | ge P. Kalas Funeral Home Oxon Hill, Md. 20745 | | | | | | |
| Physician 'Medical | 23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardiovascular disease | spiratory arrest, shock, or heart Approximate Inten Between Onset at Death | | | | | | |
| ed nsit Examiner | or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| 760, cate be executed physician and he burial - transit | X UNPENDED AMENDED 23a, PII, 27, perME, G883 9/22/08 TT | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans | | | | | | | | |
| P.O. Be es that the de igned by the be detached for the beached | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | |
| cords, law requires, has been sig | 26 Place of Death (Check onl | 24a. Was an autopsy performed? 1 Ves 2 No 124b. Were autopsy findings avail prior to completion of cause death? | | | | | | |
| tal Recting The certificate ector, page | 25. Was case referred to medical | F-1 F-2 | | | | | | |
| n of Vita | 1 V Yes 2 No 128a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28 | 8d. Describe how injury occurred | | | | | | |
| Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si tedy filled in by the funeral director, page 2 should be | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28 | 8f. Location (Street and Number or Rural Route Number, or Town, State) | | | | | | |
| Dir To the Hospital o within 24 hours at To the Funeral C | | ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) | | | | | | |
| To d withi To d | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at to and manner stated. 29b. Signature and title of certifier O.C.M.E. | 29d. Date signed (Month, Day, Year) August 31, 2008 | | | | | | |
| P.D | 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD | 21201 | | | | | | |
| Sta Registr | te 31. Date filed (Month, Day Year) 32. Registratis Signal fre | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 4:40 PM 8 James Nagle 23 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Medical Baltimore University of Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 □ F 222-42-1279 52 IL Director December 27, 1955 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 ☑ No Director MD Cecil Elk Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 Rail Lane 21920 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Master Technician Automotive 12 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic eve Marlin M. Nagle 2 Eileen L. Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Sue Nagle/Wife 240 Rail Lane., Elk Mills, MD 21920 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Rising Sun, MD Rosebank Cemetery August 29, 2008 ature of Funeral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pelvic Fracture /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MELICAL EXAMINER Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 1 Yes 2 □ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 8/21/08 7:20 PM 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director; 2 Accident Motorcycle collision filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide street Route 273 and Calvert Rd Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2047118 (Item 23a) (Type, Print) 30. Name and address of person who con 32. Registrar's Signature St Baltimore, MD S Greene 0 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** George Raymond Nalley 16, 2008 11:45 PM August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 148 Konrad Morgan Way Lothian Anne Arundel If Under 1 Year | if Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Months Hours 1127 M 2 □ F 80 579-32-2666 Director Sep 17, 1927 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f show ner must be notifled at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Lothian 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 272 --- any InJury or other trainment. 148 Konrad Morgan Way 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Key Code Operator U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George M. Nalley Louise Boswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rose M. Nalley (wife) 148 Konrad Morgan Way Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug 22 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD 4 □ Donation 5 □ Other (Specify) 2008 Ft. Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL **Physician** IMFARCTION MACHEDIATE /Medical Due to (or as a consequence of): **Examiner** GANGRENE MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown POST - HERPETIC NEURALGIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform CHRONIC SEVERE PACN 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. David Rodriguez, MD

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

DRIVE

GERMANDUN

completed cause of death (Item 23a) (Type, Print)

DOCTURS

32. Registra Signature

- 3 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Aug Physician 20 2ŎÔ8 Marion Porter 2:11 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Kris-Leigh Assisted Living Davidsonville (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan 25 1920 Birthplace (State or Foreign Country)
 NTSZ Social Security Number **Funeral** Days Hours 1 □ M 2 🖾 F NY 053-16-6772 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, "to "hod call Even from 1, ust by notified at 1 ☐ Yes 2 No Director Anne Arundel Lothian MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20711 USA 43 Danile Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify. <u>چ</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Precision Equip. Co. Coil Winder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any linjury or other traumatic event ODE. Be Mary E. Retallatk Andrew C. Cornett ပ 19b. Mailing Address (Street and Number of Rural Route Number, City, or Town, State, Zip Code)
43 Danile Drive, Lothian, MD 20711 19a. Informant's Name/Relationship (Type. Print)
Mary I. Watters—Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 8/25/2008 Farmingdale, NY 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn Cemetery 22. Name and Address of Facility Raymond Funeral Service Signature of Funeral Service Licenses Michael Raymond per DVR M00479 La Plata, MD 20646 Approximate Interval Between Onset and Death Year 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Anemia /Medical Due to (or as a consequence of) Examiner Gastrointestinal bleeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and-trar Due to (or as a consequence of): burial P.O. Box 68760, physician Physician/Medical the attending p for use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a ∐Yes 211XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe this certificate 1 ☐ Yes 2 No 2 XNo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: X | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 ☐ Yes XIX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: **X**■ Natural 5 Pending investigation To the Hosping, - within 24 hours after death.

To the Funeral Director: A death. 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide cal 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Menth, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

w

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sharon M. Messics MD, 821 W Benfield, Suite 8, Severna Park, MD 21146

32. Registrar's Signature

2008

D41586

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

| | | 1 | State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Cer | tificate of Death | Re | g. No. 2008 2 | 8717 |
|--------------------------------|--|-----------------|---|---|---|--|------------------------------------|
| | Physicia | | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | 23, 2008 3. Tirr | ne of Death |
| | /Medic | al - | Rogerlene Price 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | August | 4c. County of Death | - |
| | Examin | er ' | Prince George's Community Hospital | Cheverly | | Prince Georee | |
| | Funeral Director | | 5. Social Security Number 242-56-7894 6. Sex 1 M 2 K 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, 12–29–1 | Year) 9. Birthplace (St Country) 937 Sampson | Co., NC |
| | and w | _ <u> </u> | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc | cation | | | de City Limits |
| | Mary | tor | MD Prince George's Largo | | | | Yes 2 □ No |
| | or 282 | Director | 10e. Street and Number | 10f. Zip Code 20774 | | og. Citizen of What Country? Inited States | |
| | sath w | <u>a</u> | 500 North Harry S. Truman Drive | Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto | | 14. Race - American India | an, |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinat must be a differed and once. | | 1 TV95 2 TXNO | lf Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 🋣 No Specify: | Rican, etc.) | Black, White, etc. Specify: Black | |
| Baltimore, Maryland 21215-0036 | n 72 hou "natura edical E | Be Completed by | 15. Decedent's Education (Specify only highest grade completed) (Give | dent's Usual Occupation kind of work done during most of work DO NOT use retired) | ing | 16b. Kind of Business/Industry | |
| 212 | d withi giene. er thar | mo. | Elementary/Secondary (0-12) College (1-4or 5+) Nurse | Assistant | | Nursing Home | |
| nd | be file Ital Hy Id othe event | Be (| 17. Father's Name (First, Middle, Last) Murry Gerald | 18. Mother's Nam Katie N | | Maiden Surname) | |
| rya | hould nd Mer marke matic | 욘 | | ng Address (Street and Number or Ru | ral Route Number | ; City or Town, State, Zip Code) | |
| Sa | alth ar 27 is sr trau | | Claudelene Price (daughter) 8629 | Seasons Way Lank | am, MD | 20706 | |
| ore, | jes 1 a t of He If item or othe | | | matory or other place) | | 20c. Location - City or Town, Sta Brentwood,MD | ate |
| ij | iit. Pag artment artant: I injury c | | ADDenstion F Other (Specify) FOTL LING | coln Cemetery 8/2 2. Name and Address of Facility For | | | ! |
| Bal | perm Depa Impo any li | | 21. Signature of Fulletan Service Accessee | 401 Bladensburg H | Road Br | entwood, MD 207 | 22 |
| 68760, | Physician be executed Examin and physician and the purial-transit the purial-transit | edical Examiner | 23a. Part 1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | buant fau | | | ximate all Between and Death |
| O. Box 68 | ath cert attending or use a | Physician/Med | | ☐ Ectopic pregnancy ☐ Other (specify) | | 23d. Date of delivery Month Day | Year |
| σ. | w requires that the de s been signed by the a should be detached t | by | Part II. Other significant conditions contributing to death but not resulting in the u | underlying cause given in Part I. | | bacco use contribute to the causes es 2 ☐ No 3 ☐ Probably | se of death? |
| of Vital Records, | The ate h | Completed | | 06 Pleas of Do | 24a. Was a autop perfor 1 □ Yes ath (Check only o | sy prior to completion death? 2 ZNo 1 Yes 2 No | on of cause of |
| V:t | Physician: this certific | To Be | 25. Was case referred to medical examiner? 1 Yes 2 N No Hospital: 1 Nnpatient 2 □ ER/Outpatie | Other: | | lence 6 Other (Specify) | |
| | Attending Phirit death. ector: After this by the funeral | tion: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year) | of 28c. Injury at Work? M 1 □ Yes 2 □ No | 28d. Describe h | now injury occurred | |
| Division | or Attendate death Director: / | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify) | treet, factory, office | 28f. Location (5 City or Tov | Street and Number or Rural Rou vn, State) | te Number, |
| | Hospita 24 hours Funeral tely filled | Medical C | | ath occurred at the time, date and place investigation, in my opinion, death occ | e, and due to the urred at the time, | cause(s) and manner as stated date and place, and due to the c | cause(s) |
| | To the within 2 To the comple | Me | | 29c. License number | | 29d. Date signed (Month, Day, | Year) |
| | | | > Strum re | 146998 | | ungust 23 | 15002 |
| sk | 23 | | 30. Name and address of person who completed cause of death (Item 23a) (Type Stum Tu MD 34LS Ho | multon St | Hyafl | ovitle mb 2 | 20782 |
| | St Regist | ate | 31. Date filed (Month, Day, Year) AUG 2 6 2008 | • | , | | |

Registrar

| | | | 1 - For amend #14 | State of Maryl Per FH G883 | and / Dep. 9/23/08 | artment of h | lealth and M Death | lental Hyg | iene 008 | 28718 | | | | |
|--------------------------------|--|------------------|--|---|-----------------------------|---|--|--|----------------------------|---|--|--|--|--|
| | | | 1. Decedent's Name (First, Middle, | Last) | | | | 2. Date of Deal Month | h Day Year | 3. Time of Death | | | | |
| | Physici /Medio | | Barry Al: | lan Posey | | | | August | 21, 2008 | 8:01 A M | | | | |
| 1 | Examin | - 10 | 4a. Facility Name (If not institution, | give street and number) | | 4b. City, Town, o | or Location of Death | | 4c. County of De | ath | | | | |
| | | | Fort Washington | | | Fort Was | | | Prince G | | | | | |
| | Funeral | | | 5. Sex 7. Age (In 1X M 2□ F 42 | yrs. last birthday, Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | Date of Birth (Month, Day) | | irthplace (State or Foreign Country) | | | | |
| | Director | | 215-62-9188 Usual Residence of Decedent | ,- | 113. | | | 3-10-19 | 066 C1 | inton, MD | | | | |
| | and w | | 10a. State 10b. County | 10c | City, Town or L | ocation | | | | 10d. Inside City Limits | | | | |
| | Maryl f sho | ō | MD Charle | es W | aldorf | | | | | 1 ☐ Yes 2 💢 No | | | | |
| | 288. | rec | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What (| Country? | | | | |
| | 3a of | <u> </u> | 6320 Deerwood | Court | | 20603 | | | United St | ates | | | | |
| | death with the Maryland me 23a or 28a-f show rmust te matthed at | Funeral Director | 11. Marital Status | 12. Was Decedent Ever | in U.S. 13. | Was Decedent of h | Hispanic Origin? (Spean, Mexican, Puerto | ecify Yes or No- | 14. Race - An Black, Wh | rencan Indian, | | | | |
| 9 | or Ite | | 1 Never Married 2 Marrie | Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give | | 1 ☐ Yes 2 X No | | nican, etc.) | | ack White | | | | |
| 93 | ral', | b S | 3 Widowed 4 Divorced | Year or Dates: | | 10103 241110 | | | Specify | die A | | | | |
| 5-0 | 72 h | Completed | 15. Decedent's (Specify onfy highest | Education grade completed) | 16a. Dece (Give | dent's Usual Occup kind of work done | pation during most of work d) | ing | 16b. Kind of Busines | s/Industry | | | | |
| 2 | Atthin han han | mpi | Elementary/Secondary (0·12) | College (1-4or 5+) | | | nd) | | D • · | | | | | |
| 2 | lled v tygie her t | | 12 17. Father's Name (First, Middle, L | act) | Lock | smith | 18. Mother's Name | e (First Middle | Private | | | | | |
| auc | tall he fi | Be | Earl Vernon Pose | | | | Shirley | | | | | | | |
| ž | hould d Mer marke | ဥ | 19a. Informant's Name/Relationshi | | 19h Mail | ing Address (Street | | | City or Town, State | Zin Code) | | | | |
| Baltimore, Maryland 21215-0036 | d 2 s th an 7 is r traur | | | | | | | | | , _, _, | | | | |
| á | 1 an Heal Hern 2 | | Melissa A. Posey 20a. Method of Disposition | (EX-Wile) | 05. Place of Disp | Deerwood osition (Name of | Ct. Wald | orf, MD | 20c. Location - City | or Town, State | | | | |
| ᅙ | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. | | 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Fort Lincoln Cemetery 8/24/2008 Brentwood, N | | | | | | | | | | | |
| 量 | nit. Partme | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral | | | | | | | | | | | |
| Ba | permi Depa Impo any i | | Ruhut than 4 3401 Bladensburg Road Brentwood, MD 2 | | | | | | | | | | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| | Physician | | Immediate Cause (Final | Christiane. | Mush | il loud | kemin | | | Interval Between Onset and Death | | | | |
| | /Medical | | disease or condition resulting in death) | Due to (or as a cor | | ig become | C0000111 | | | | | | | |
| | Examiner | | - 1550 WW | | | | | | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a cor | nsequence of): | | | | | | | | | |
| | death certificate be executed e attending physician and of for use as the burial-transit | Examiner | Cause (Disease or injury that initiated events | с | | | | | | | | | | |
| 760, | e exe | | resulting in death) Last | Due to (or as a cor | | | | | | | | | | |
| | ate b physic the b | dicai | 3 | d | | | | | | | | | | |
| Box 68 | leath certifical attending phy I for use as th | Physician/Med | IF FEMALE: | 23c. If yes, outcome of pr | 0000000 | | | | 8018 | | | | | |
| Bo | attenc for us | lan | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 2 4 Pregnant at time | Fetal death 3 | □Ectopic pregnanc □ Other (specify) _ | у | | 23d. Date of o Month | Day Year | | | | |
| | he de the ched | ysic | 1 □ Yes 2 □ No 9 □ Unknown | 9 Unknown | or death 5 | Other (specify) _ | | | | | | | | |
| P.O. | The law requires that the deatate has been signed by the areage 2 should be detached to | , Ph | Part II. Other significant condition | s contributing to death but no | t resulting in the | underlying cause gr | ven in Part I. | 23e. Did to | bacco use contribute | to the cause of death? | | | | |
| ds | uires 1 sign 1d be | d by | | | | | | 1 □ Y | es 2 ⊟√l o 3 ⊟ | Probably 4 Unknown | | | | |
| õ | w requir been si should | Completed | | | | | | 24a. Was a | an 24b. Were | autopsy findings available | | | | |
| Be | The lav | E D | ' <u> </u> | | | | | autop | sy prior t med? death | o completion of cause of | | | | |
| ā | | C | 25. Was case referred to medical | | · | | ac Place of Past | 1 ☐ Yes | | es 2ENo | | | | |
| 5 | Physiclan: r this certifica ral director, p | 8 | examiner? | Hospital: | 2 ER/Outpatie | ent 3 DOA Ot | 26. Place of Deat | | ence 6 □Other (S | necify) | | | | |
| of | Phy or this oral d | n: To | 27. Manper of Death | 28a. Date of Injury | | | | | ow injury occurred | DBC II y) | | | | |
| ion | nding tth. :: Afte | atio | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig | | ar) Injury | | ork?]Yes 2 □ No | | | | | | | |
| Division of Vital Records, | Atte | E C | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine | ot be 28e. Place of Injury - building, etc. (S) | At home, farm, s | treet, factory, office | | 28f. Location (S City or Tow | | Rural Route Number, | | | | |
| ā | s affe s affe al Dir | Certification: | | ounding, etc. (3) | - 30.,7/ | | | J., J. 10W | | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, | | 29a. Certifier 1 Certifying (Check only 2 Medical E | Physician: To the best of my xaminer: On the basis of exa | knowledge, dea | th occurred at the t | ime, date and place, | and due to the o | ause(s) and manner | as stated. | | | | |
| | the H in 24 the F iplete | Medicai | one) | and manner stated. | ation and i | | | | | | | | | |
| | To To To To To To To To To To To To To T | 2 | 29b. Signature and title of cartifier | | | | se number | | 29d. Date signed (Mo | onto, Dey, Year) | | | | |
| | | | - Webs | my | | D003 | 05120 | (| Myus r 2 | 1 CNS | | | | |
| nR | (2) | | 30. Name and address of person v | who completed cause of death | (Item 23a) (Type | Print) | 55120 310 Waa | ant | 00 2 2 2 2 2 2 | | | | | |
| | | | 31. Date filed (Month, Day, Year) | (4) 1328 Janhan 32. Registrar's S | Signature | It Just | JIP WOOD | angun | DC 20032 | | | | | |
| | Sta | ate | ALIG 9 6 2008 | L. Hoyistial's 3 | hat s | | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:37 AM 2008 BEVERLY PATTERSON AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Nove Hours Min. 8. Date of Birth (Month, Day, Year) 06/17/1934 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 218-30-3388 **Illinois** 74 **Director** Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 TYPes 2 □ No Director Delaware Sussex Millsboro 10e. Street and Number 10f. Zin-Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturally njury or other traumatic averally." 19966 26542 Outrigger Cove Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 🖾 No White 1 ☐ Yes 2 XNo Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done d life, DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 12 Private Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Comstock Kosatka Dorothy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 65, Eleanor, WV 25070 Mark Nuckolls - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State 8/29/2008 4 Donation 5 Other (Specify) Brentwood, MD Fort Lincoln Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Due ti (or as a consequence of) disease or condition resulting in death) intarction /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de ۾ 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 50 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 1 KInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA ည funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

The law requires that the death certificate be executed Box 68760, PO Division of Vital Records, certificate has After this death. or Attend after death Director: /

the

24 hours To the within 2

NATALIA 31. Date filed (Month, Day, Year) State AUG 2 6 2008 Registrar

29a. Certifier

(check only one)

29b. Signature and title of certifier

Medical

GLEBOVA

and manner stated

29d. Date signed (Month, Day, Year) 29c. License number MD 21, 2008 RES DOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

600 North Wolfe St, Baltimore, MD, 21287

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Department of F Important: If Ite any Injury or ot once,

Be

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Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

James Jensen Raun

4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print) Mary Ellen Raun/Daughter

1 ☐ Burial 2 Macremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 0 8 2008

31. Date filed (Month, Day, Year)

ND

Physician /Medical Examiner

The law requires that the death certificate be executed g physician and as the burial-trans To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

| | 21. Signalure of Funeral Service Licens | Hick 103 | ne and Address of Facility As Home for Func W. Stockton Sti | erals, P.A reet. Elkt | on, MD | 21921 | | | | |
|---|---|---|---|--|--|--|--|--|--|--|
| | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | olications that caused the death. Do not enter the one cause on each line. | | | | Approximate Interval Between Onset and Death | | | | |
| | Immediate Cause (Final disease or condition resulting in death) | a | e | | | Onset and Death | | | | |
| iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. IS Charic Course to (or as a consequence of): | | | | | | | | |
| lical Exam | that initiated events resulting in death) Last | c. (DV) Ny Altry Disease Due to (or as a consequence of): d. Conduction System Disease | | | | | | | | |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) | | | | | | | | | |
| ed by Pf | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Yes 2 No 3 P | | | | | | | | | |
| omplet | Hyperlips de | ? death? | ere autopsy findings available or to completion of cause of ath? | | | | | | | |
| Bec | 25. Was case referred to medical | | 26 Place of Deat | th (Check only one) | | | | | | |
| | examiner? 1 ☐ Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 | Other | ome 5 K Residence | 6 □Other (Sp | ecify) | | | | |
| ation: | 27. Manner of Seath 1. Seath 5 ☐ Pending 2 ☐ Accident investigation | | 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how in | njury occurred | | | | | |
| Medical Certification: To | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injury - At home, farm, street, fabuilding, etc. (Specify) | actory, office | and Number or F ate) | Rural Route Number, | | | | | |
| edical (| 29a. Certifier (Check only one) | ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated. | urred at the time, date and place, gation, in my opinion, death occu | , and due to the cause rred at the time, date | e(s) and manner a and place, and du | as stated. ue to the cause(s) | | | | |
| Ž | 29b. Signature and title of certifler | | 29c. License number | 29d. | Date signed (Mor | nth, Day, Year) | | | | |
| | A | | | | | | | | | |

Social Worker

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris & Co., Inc.

Religion

20c. Location - City or Town, State

West Chester, PA

21915

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Scalapino

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

August 29.

124 Woodside Drive, Chesapeake City, MD

2008

DHMH 17 Rev 1/2001

State

Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 19, 2008 1728 Rieman Paul Rhinehart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Temple Hills Prince George's 7204 Karen Anne Drive 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Yrs. 79 311-26-7545 1/22/29 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MDDirector Prince George's Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7204 Karen Anne Drive 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X1 Yes 2 No If Yes, Give 1952-Year or Dates: 1954 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Consumer Safety Officer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Keene Edward Rhinehart 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7204 Karen Anne Dr., Temple Hills, MD 20748 Marguerite M. Rhinehart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 8/25/08 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Respiratory Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Carcinoid Tumor Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as e nonsequente of): Examine The law requires that the death certificate be executed Tonque Cancer sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Stage 3 Chronic Kidney Disease Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

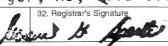
1 □ Yes 2 □ No performed? 1 Yes 2 X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Attending (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director; / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital or To the Hospital or within 24 hours after To the Funeral Di completely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/22/08 D0016646 30. Name and address of pason who completed cause of death (tem 23a) (Type, Print) MD, \$01 Old Branch Ave, #202, Clinton, MD 20735 Stephen Goldberger,

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) AUG 2 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8-27-2008 Day Year **Physician** 9:10 P M Fav Barker Somers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner College View Nursing Home Frederick Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 8-28-1919 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🗗 F 064-07-4594 88 DE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director Montgomery Chevy Chase Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ö 20815 U.S.A3 East Irving St. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🗓 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify. Specify: à 3 ☑ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hcmemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 6 William Barker Catherine White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Pages 1 and 2 3 East Irving St. Chevy Chase, Md. 20815 Pam Somers (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Smithsburg, Md. Smithsburg Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg,Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician remen ho disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 N 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Harsing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death. e Funeral Director: A bletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the ura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson Str. Frederick MD 21702 Shah 1homas Year) 92. Registrar's Signature State 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 08 22 2008 Margaret M. Sweeney /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shock Trauma Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Days 1 □ M 2**X**□ F Yrs. Jan. 11, 158-14-2734 Máryland 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location la or 28a-f show t be notified at 10b. County 10a. State 1 ☐ Yes 2 K No Director Maryland Cecil Port Deposit death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 175 Craigtown Road 21904 U.S.A. Items 23a must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 7 is marked other than "natural", or Iten traumatic event, the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: ģ White 3 ₺ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Procurement Division tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Contracting Officer Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F Clifton R. Miller Clara Brown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) د. Pages 1 and المساهمة و Health and المساهمة و المساهم و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهم و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة و المساهمة 171 Craigtown Road, Port Deposit, Maryland 21904 Judy S. Dawson (Great Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If It any injury or o 1X Burial 2 ☐ Cremation 3 ☐Removal from State 08/28/08 Port Deposit, Maryland 4 □ Donation 5 □ Other (Specify) Hopewell Cemetery 21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland - 30 perfective arres 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresplock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Injunes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2□ No 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of after death.

Director: After 5 ☐ Pending investigation Injury 1 Natural 13:40 1 ☐ Yes 2 XNo Driver-dump truck impact 8/22/08 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1336 Tomoc Highway Port Deposit, MD Roadway To the Hospital within 24 hours a To the Funeral D 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

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Box 68760,

P.O.

Records.

Division or Vital

State Registrar

31. Date filed (Month, Day, Year) AUG 2 6

fraunal

29b. Signature and title of certifier

Shock

55 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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Balhmere.

29d. Date signed (Month, Day, Year)

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rus, Ashila Jain

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Seawright 3:10P Curtis Aug 12,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Temple Hills 6212 Allen Ct 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Director 13, 1938 South Carolina <u>249 56 1427</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I fiem 27 is marked other than "natural" --- any injury or other traumatic exercise. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Prince George's Maryland Temple Hills 10e. Street and Number 10g. Citizen of What Country? 6212 Allen Court 20748 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXNo ş Specify: **Black** Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman GSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) T.C. Seawright Ola Moore မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Seawright (Wife) 6212 Allen Court, Temple Hills, MD 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Resurrection Cemetery Aug 21,2008 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STOMACH CANCER 30 month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the s detached f 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, sign be 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 After this certificate funeral director, pag 1 ☐ Yes 2 📉 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier D26250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. MATILDA H. MERCANTILE 31. Date filed (Month, Day, Year) AUG 2 gistrar's Signatur State 2008 2 Registrar

amend line 26 per phy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth depat 08/21/08 dl State of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Aaron W. Solliday August 11, 2008 6:00 PM/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 14806 White Hall Avenue Accokeek If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. Feb. Director 1928 Pennsylvania 230-20-9302 80 15, Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Exercitor is ust be retified at 1X Yes 2 □ No Director Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 USA Funeral 4006 Croydon Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: ≥ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Goods Receiver Giant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert E. Solliday, Sr. Emma P. Bealer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. 14806 White Hall Avenue Accokeek, MD 20607 Mark R. Solliday/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/13/2008 Glen Burnie, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home alea 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PARKINGON'S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. requires that the death certificate be Physician/Medical as attending properties of the second se IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a P.0. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Recidence 6 Other (Specify) Son's residence 1 Yes 2 WNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Attending 1 V Natural 5 ☐ Pending investigation ospital or Attendi hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) To the Ivilian 24 and manner stated. 29b. Signature and title of certifier 29c. License number anaxaver MD D16619 August 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . VERGARA- SCARES 4041 POWDERMILL RD. CALVERTON 31. Date filed (Month, Day, Year) AUG 21 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 28721 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Addust **Physician** Samantha Meza Silva **የ**ማ,2008 1218 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | Aug. 19, 2008 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F Yrs Maryland none **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 X No Director MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 118 DuVall Lane 20877 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Nicaraguan/ 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 X Yes 2 ☐ No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "Salvadoren Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental and 2 should be Mental Jorge Alexander Meza Glenda Silva or other traumatic 19a. Informant's Name/Relationship (Type. Print) father/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trauonce. Jorge Alexander Meza 118 DuVall Lane Gaithersburg, Md 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/22/2008 All Souls Cem. Germantown, Md 4 □Donation 5 ☐ Other (Specify) neral Service Licens PHYTE TPACTOS RINALDI FUNERAL SERVICE, P.A. 21. Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Partf. Enter the dkease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) XTREME MEMATURITY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (brids a consecuence of) Examiner Hospital or AttendIng Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Hospital Other: 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury nours after death.

neral Director: Ai

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DD 55699 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person BEHRAM 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 STEVE 31. Date filed (Month, Day, AUG 2 Registrar's Signature State 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20001 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kathleen Silva Aug. 19, Meza 2008 1424 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 19, Year) Aug. 19, 2008 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Davs Maryland none Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Montgomery Gaithersburg 1 ☐Yes 2 XNo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 118 DuVall Lane 20877 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 **⋈** No 1 Never Married 2 Married Nicaraguan, 1 XYes 2□ No Specify: NICalagu El Salvadoren White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jorge Alexander Meza Glenda Silva 19a. Informant's Name/Relationship (Type. Printfather/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 DuVall Lane Gaithersburg, Md 20877 Jorge Alexander Meza 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State All Souls Cem. 8/22/2008 Germantown, Md 4 □ Donatiog 5 Other (Special PRINTER OF TRANSPIRED FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PREMATURIT EXTREME disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a nonsecutions of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 18 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury

Physician /Medical Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

show

ns 23a or 28a-f show must be notified at

er than "natural", or items. the Medical Examiner mu

of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me

jo <u>________</u>

Department or Important: If it any injury or once. ō

death \

Pages 1 and 2 should be filed within 72 hours after

3altimore, Maryland 21215-0036

Director

Completed by Funeral

Be

Physician/Medical Examiner the burial-tran signed by the a þ Completed certificate has birector, page 2 s director Be ၉ this Medical Certification: After within 24 hours after death

To the Funeral Director:
completely filled in by the

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical Examiner: On the basis of examination and/or investigation in my policies

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

DD 55699

Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 108

Seman , MD 30. Name and ad as s of person who completed cause of death (Item 23a) (Type, Print)

BEHRAM, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND STEVE

31. Date filed (Month, Day, Year) State Registrar

AUG 2 2 2008



Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0scar Schneider 2008° August 18, 2:05A. M /Medical 4c. County of Death
Montgomery o. City, Town, or Location of Death Rockville 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home 5. Social Security Number 8. Date 1 Birth May 11, 1915 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours 116-05-7770 1 XM 2 ☐ F New York, NY 93 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at New Jersey Union Summit Director 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 41 Springfield Avenue, #323 07901 United States 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3X Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Yorkville Paper Co. 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Schneider Fanny Lichtenstein ပ္ 19b. Mailing Address (Street and Numb#407/ral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at Important: If item 27 is any injury or other trau once. 3001 Veazy Terrace, N.W. Washington, D.C. 20008 Francine Weinbaum -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Township city of Washington, Burial 2 Cremation 3 Removal from State Beth El Cemetery 8/20/2008 New Jersev 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of run Service Licensee Bonald WorsBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, princert failure. List only one cause on a ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has birector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 20 No Other: ို 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation Injury s after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar AUG 22

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month August 19, A1ma Mav Russell Turner 2008 8:24 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2100 Brickhouse Road Dunkirk Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/29/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🗓 F Yrs. 83 Director 213-24-4059 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shedleal Examiner must be notified 1 ☐ Yes 2 No Director MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6685 Southern Maryland Blvd. Funeral 20736 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 10. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ☑ Widowed 4 ☐ Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) postal clerk U.S. Postal Service 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Wilson Russell Booze ပ Marguerite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah T. Wood, daughter 930 Carson Road, Huntingtown, MD other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any Injury or or 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Cemetery: 08/25/2008 Owings, MD Mt. 22. Name and Address of Facility ure of Funeral Service Licen Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** congestive heart failure years /Medical Due to (or as a consequence of): Examiner coronary artery disease Sequentially list conditions. Examiner duny, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? ρ Month Dav Year signed by the a 5 Other (specify) 1 ☐ Yes 2 💢 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should severe aortic stenosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? tal or Attending Physician: To safter death.

al Director: After this certificate ed in by the funeral director, pa 1∐ Yes 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Nother State home ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier D 29c. License number 29d. Date signed (Month, Day, Year) D 19427 Physician August 19, 2008 ttendin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwar T. Munshi, M.D. 110 Hospital Rd., #303, Prince Frederick, MD 20678

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

AUG 2 1 2008

32. Registrar's Signature

08-06387 Leroy Tyler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20a-c Fer FH 8883 9/24 08 JH

2008 28731

| | | 1. For State Registrar | | | | Death | | | | | leg. No. | | | |
|--|--|---|--|---|--|--|--|---|------------------------------|--|---|--|--|---|
| Physic | | | lle,Last) | - | | | | | - 1 | Date of Dea Month | Day | Year | 1 | of Death |
| edical Exan | niner | Leroy | Tyler | | Sr. | | | | | August 2 | 1, 2008 | | | 2 hrs |
| F 1 | | 4a. Facility Name (if not instituti Southbound Washing | | | 4 | Beltsville | | cation of I | | | Pr | County of De ince Geor | ge's | 1 |
| Funera | 1 | 5. Social Security Number | 6. Sex | 7. Age (In yrs. last | t birthday) | " | | | | | | (MM/DD/YYYY) 9. Birthplace (State or Fore | | |
| Directo | | 578-64-4518 | 1 X M 2 F | 60 | Yrs. | Months | Days | Hours | Min. | Janua | ry 6 | 1948 | D.C. | |
| ž. | | Usual Residence of Decedent 10a, State 10b, County | | 10c City T | own or Location | on . | | | | | | | 10d. In: | side City Limits |
| ow any | | D.C. | | | | nington 1 | | | | | | | 1 X | Yes 2 No |
| faryland 28a-f show | 호 | 10e. Street and Number | | | | _ | | | | | 10g. Citiz | Citizen of What Country? | | |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygene. 27 is marked other than "matural", or items 23 and 28 set-sho 27 is marked other "promises the midfall of order | | 2603 Naylor Rd, | S.E., Apt.# | 2 | 20020 | | | | | | | U.S. | | |
| ms 23 | eral | 11. Marital Status | Armed Fr | edent Ever in U.S. | | Decedent | | | | | 0- | Race - An White, etc. | | an, Black, |
| er death | Funeral | 1 Never Married 2 XI 3 Widowed 4 D | Married 1 Yes ivorced If Yes, Give Yea | 2 X No | ii roo, spoorly cooling marketing to | | | | | | | an | | |
| irs aft | b S | 15. Decedent's Education (Sp | or Dates: | | 16a. Decedent | 's Usual Oc | upation | (Give ki | nd of wo | rk done | 16b. K | ind of Busine | ss/Industry | |
| 2 hou | eted | Elementary/Secondary (0-12 | | | during most of working life. DO NOT use retired) | | | | | | | | 76.7 | |
| thin 7 | Professional Truck Driver 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna | | | | | | | | | | | - Caripu | -17 | |
| 21215-0036 uld be filed within 73 Mental Hygiene. marked other than | S | 17. Father's Name (First, Middl | | 18.Mother's Name (First, Middle, Maiden Surname) | | | | | | | | | | |
| 2121; uld be fil Mental I- marked | Be | Ieroy Tyler | | | | | | | | mpson | | | | |
| Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma | To | 19a. Informant's Name/Relation Victoria Tyler-S | | | | | S.E. | #2, | Washin | gtan, | ty or Town, S D.C. 20 | 020 | | |
| and 2 | | 20a. Method of Disposition | | | lace of Dispos | tion (Name | of ceme | tery, | 8/2 | 9/200 | 8 20c. t | ash ish | et Town, | be. |
| Baltimore, permit. Pages I an Department of Her Important: If ite | | 1 XBurial 2 Cremati | | UIII State | Ob. Place of Disposition (Name of cemetery, critical Park 8/29/2008 8/29/2008 20c. Wash Tilg Low, Size 12008 | | | | | | | | | |
| Itimen returnen | | 4 Donation 5 Other 21. Signature of Funeral Service | | TALL | 22. Name and Address of Facility Bornette & Assoc. Fune | | | | | | | | 1 Home | Tro |
| Ba perm Depa Impe | | 21. Signature of 1 directal Scivic | | | | 2504 28 | | | | | | . Turkic | LIMIC | II. |
| Physicia | _ | 23a. Part I. Enter the disease, | or complications that o | aused the death. | | | | • | - | | | ck, or heart | | oximate Interval |
| /Medica | · - | failure. List only one caus | se on each line. | | | | | | | | | | betv | Death |
| xamine | er | Immediate Cause (Final diseas or condition resulting in death) | | a consequence of) |): | | | | | | | | | |
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| | Je Je | if any, leading to immediate cause. Enter Underlying Cause | | a consequence of) |): | | | | | | | | | |
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| executed ian and | i - I | UNPENDED | AMENDED | | | | | | | | | | | |
| 8760, tificate be executed ng physician and | s the burial - tr | IF FEMALE: | 23c. If yes, | outcome of pregn | nancv | _ | | | _ | | 23 | d. Date of del | | |
| 687 ertific | · · · · | 23b. Was decedent pregnant in | | | | | | | | | 20 | | ivery | Year |
| Box 68 e death certi the attendin | SO . | past 12 months? | 23c. If yes, outcome of pregnant in the 23c. If yes, outcome o | | | | | | | псу | 20 | Month | Day | 1001 |
| | 5 S | past 12 months? | 4 Preg | nant at time of dea | 2 Fe | tal death her (Specif) | 3 | Ectopic | pregnar | ncy | | Month | | Teal |
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| Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the | y filled in by the funeral director, page 2 should be detached Certification: To Be Completed by Phy | Part II. Other significant conditions 25. Was case referred to mediexaminer? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Properties 2 ✓ Accident 3 Suicide 6 Conditions 4 Homicide 29a Certifier | Diknown g Unkr ditions contributing to Unkr d | Inpatient 2 Inpatient 2 e of Injury th, Day Year) coe of Injury - At ho Interstate/E est of my knowledges of examination ar | 2 February F | 26 t 3 DO Injury 28 ret, factory, corred at the tition, in my co | Place of Co. Injury 11 Yes | of Death of | Check control Nursing? | 23e. Di 1 24a. W au pe 1 Ye Ye only one) g Home 5 28d. Descri Driver of 28f. Locatic or Tow Southbound | d tobacco Yes 2 sas an topsy frormed? s 2 N Residue how in auto in n (Street n, State) d Washi ause(s) a atte and pl | use contribut No 3 24b. Wer prio dea lo 1 ence 6 ury occurred collision we and Number of manner as | Day e to the cat Probably e autopsy fr to completh? Yes Other: Scen of Rural Ro nore Pkwy stated. to the caus | use of death? 4 Unknown indings available ion of cause of 2 No e rcycle ute Number, City /, Beltsville, ME |
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| Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the | y filled in by the funeral director, page 2 should be detached Certification: To Be Completed by Phy | Part II. Other significant conditions 25. Was case referred to mediexaminer? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Properties 2 ✓ Accident 3 Suicide 6 Conditions 4 Homicide 29a Certifier | ending vestigation ould not be tetermined (Specify and manner tiffer | Inpatient 2 e of Injury At how Interstate/East of my knowledge of examination are stated. | ER/Outpatien 28b. Time of 0509 hrs ome, farm, stree Express ge, death occund/or investigation | 26 t 3 DO Injury 28 rred at the tition, in my c | Place of Control of the Control of t | of Death of Death of Death of A.E. | Check c Nursing No c. | 23e. Din 1 24a. W au pointy one) g Home 5 28d. Descrit Oriver of 28f. Location or Tow Southbourn due to the cet the time, d | d tobacco Yes 2 sas an topsy rformed? s 2 sas an topsy rformed? s 2 sas an topsy rformed? s 2 sas an topsy rformed? s 2 sas and to in auto in | use contribut No 3 24b. Wer prio dea lo 1 ence 6 ury occurred collision we and Number of manner as ace, and due Date signed | e to the cau Probably e autopsy f to complete Yes Other: Scen or Rural Ro nore Pkwy stated. to the caus (Month, Da | use of death? 4 Unknown indings available ion of cause of 2 No e rcycle ute Number, City /, Beltsville, ME |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20:42^Рм Month 08-22-2008 SR. TYRONE KEVIN WALLS, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Southern Maryland Hospital</u> Prince George's Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.7 - 1.3 - 1.952 5. Social Security Number 9. Birthplace (State or Foreign Country)
Wash., D.C. Age (In yrs. last birthday) Funeral 1 - M 2 | F 577-70-4523 Yrs. 56 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any liquy or other traumatic event than "natural" and once. Funeral 5411 Chesterfield Drive 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∰ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 - Married 1 Tyes 2 No Specify. \$ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) D.C. Public School Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Thomas Walls Katherine Pegrams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen F. Walls/wife 5411 Chesterfield Dr. Temple Hills,MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nat'1 Harmony Mem.Pk. 08-29-2008 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01246 Cedar Hill Funeral Home 4111 PA Ave.Suitland,MD ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LRO GLY CON disease or condition resulting in death) /Medical Due to (cras a consequence of) Examiner Sequentially list conditions, if any, leading to mineciate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence on The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acuto icate has been si , page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No or Attending Physiclan: After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21€ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No I Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature, and title of certifie 29d. Date signed (Month, Day, Year)

Box 68760,

P.O.

Division of Vital Records,

State

31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 28733 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day David J. Williams 4:20pm м 08/19/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairland Nursing Home Montgomery Silver Spring
Under 1 Year | If Under 24 Hrs. 7 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **№** M 2 🗆 F Months Days Hours Min Yrs. Director 79 <u>237-36-2319</u> North Carolina 05/13/29 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director 1 Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 5310 14th Street USA Funeral NW 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1952–1954 er than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married <u>م</u> 1 ☐ Yes 2 ☐ No 3 X Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Md Park &Planning Driver 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Williams James Bryant ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5449 Hightide Ct.
columbia, Maryland 21044 int of Health at: If item 27 is <u>Belinda Robinson Step-Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) Quantico National 08/29/08 Quantico, Va. 21. Signature of Funeral Service Licensee ²² Sname and Address of Facility Snead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville MD 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebellar Infaraction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was a... autopsy performed? Yes 2 1 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

the Maryland

death with

Baltimore, Maryland 21215-0036

State Registrar

Alan R. Segal Μ. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

29c. License number D52261

29d. Date signed (Month, Day, Year)

August 19,2008

1500 Forest Glen Rd Silver Spring, Md 20910

AUG 2 2 2008

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2009 1:40AM Joyce Elaine Wells /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Jasta' alish Wicomico 9.219 the Lake Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🕅 F Months Days Hours 217-30-9657 Director 05-29-1933 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 No MD Somerset Chance 10e. Street and Number 10g. Citizen of What Country? 23636 Earl Webster Road 21821 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Maryland 21215-0036 <u>م</u> 1 □Yes 2 No Specify Specify: 3 ☐ Widowed 4 🏿 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Loan Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Jones ျှ Marcella Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Sunny Drive, Waynesboro, Tammy L. Biser/Daughter Baltimore, PA17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If Its any injury or o once. 1 ≥ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery | 08-27-2008 | Chance, Maryland 21. Signature of Funeral Service Ligensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23. Part 1. Enter the disease, or complication, that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on girch line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** me /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be det significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 □ Yes 2 No 24a. Was an autonsy 2 🖪 No 1 ☐ Yes or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 29505 08-23-2008 Mame and dress of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR. SALISBURY, MD 21801 State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records. P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Pearl Scarborough Zeveney 28 2008 1730 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT 27, 19 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Director 213-12-8462 27, 1921 86 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Framing. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2328 Blue Ball Road Funeral 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Completed by Specify 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Accountant Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Scarborough ဂ Elsie Brennen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Lemon/Sister 2217 E. Huntington Drive, Wilmington, DE 20b. Place of Disposition (Name of Gilpin Manor, Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 3, 2008 E1kton, MD 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endum Co Due to (or as a consequence of): **Physician** comun /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Obstru attending p for use as IF FEMALE IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death in the past 12 mm 3 □ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) the 9 Unknown ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 □ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has i 24a. Was an autopsy certificate ha 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Certification: To 1 🗀 Yes 2 Other: 1 🗌 Inpatient 4 Nursing Home 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day 28b Time of Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 2 Accident 1 🗌 Yes 2 🗆 No within 24 hours after death To the Funeral Director: Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) (Month. Dav. Year Date file 32. Registrar's Signature State SEP 0 8 Registrar

Dr

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day Physician 2:20 AM V2 an /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner BALTinoce Rehabilitation 13Abtimore NA CARE 8. Date of Birth (Month, Day, May 8, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 1 □ M 2 □ F 81 Months Days Hours Min 246-28-7364 NC Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location MD Baltimore Lansdowne Director 1 ☐Yes 2√2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 153 Clyde Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ^{rces} Navy 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 XXNo White Specify δ 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alford Biggerstaff Ella Smith ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Biggerstaff / Daughter 1420 Andre Street, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 9/9/2008 Baltimore, MD ature of Euneral Service License Victor P. 22. Name and Address of Facility Doda Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eciden evelorovascular Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): arcinoma Kin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 2 3 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖸 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician: The law requires that the death certificate be executed and burial-trar attending physician the as for P.O. the signed by Division of Vital Records, page 2 should be has certificate funeral director, this After death. after death the

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Important: If Item 27 is marked other any injury or other traumatic event, I

Physician

/Medical

Examiner

1 and 2 should be Health and Mental

Pages 1

Hospital or Attending filled in by 24 hours a completely within 2.

State Registrar 31. Date filed (Month, Day, Year) SEP 09 2008

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TROUGE E. WILLS AT MD. 390 32. Registrar's Signature

3900

V

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

License number
DY 1365

September 6, 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| Roy Amos Bradley, | Jr. 1- For State Registrar | State of Maryland | / Departmen Certificate | | | ntal Hygie | | . No. | 008 2873 |
|--|--|---|--------------------------------|---------------------------------|---------------------------------------|-------------------|-------------------------------------|------------------------------|---|
| Physician/ Medical Examiner | Decedent's Name (First, Name) Roy | Amos | Bradley | | r. | Se Se | ate of Death Ionth I eptember | | 3. Time of Death 0106 hrs |
| | 4a. Facility Name (if not inst Eastern Boulevard | itution, give street and number and I-695 | | 4b. City, T Baltin | own, or Location Iore | of Death | | 4c. County of I Baltimore | |
| Funeral Director | 5. Social Security Number 213–68–9130 | 6. Sex 7. Ac | ge (In yrs. last birthda 52 | | | n Min | Date of Birth | ` ' | B. Birthplace (State or Foreign Country) Maryland |
| any | Usual Residence of Decede 10a. State 10b. Co. | | 10c. City, Town or L | ocation | | | | | 10d. Inside City Limits |
| 2 1 | Maryland Ba | ltimore | Spari | cows Po | int | | | | 1 Yes 2 X No |
| ith the Maryland 23a or 28a-f show notified at once. | 10e. Street and Number 7419 North Po | aint Pood | | 10f. Zip | Code 21219 | | 100 | g. Citizen of What USA | Country? |
| with the as 23a of the contif | 11. Marital Status | 12. Was Deceden | | B. Was Decede | nt of Hispanic Or | | | 14. Race - A | American Indian, Black, |
| 0036 within 72 hours after death with the Maryland piene. ter than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once ompleted by Funeral Director | 1 Never Married 2 3 Widowed 4 | 1 Yes 2 Divorced If Yes, Give Year | ? X No | | y Cuban, Mexicai $old X$ No $specify$ | | an, etc.) | White, e | |
| 5 72 hours aft "n "natural" al Examine | 15. Decedent's Education | (Specify only highest grade co | duri | | Occupation (Give | | done | 16b. Kind of Busin | ness/Industry |
| 136 thin 72 l than "y than "y than "y | Elementary/Secondary (0 | 0-12) College (1-4 or | 5+) | rdman | | | | Railroa | d |
| Limore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner. To Be Completed by I | 17. Father's Name (First, Mi | | | | | ers Name (Firs | | aiden Surname) | |
| 212 tould be d Menta is mark tic even | 19a. Informant's Name/Rela | tionship (Type, Print) | | | (Street and Nu | mber or Rural | Route Numb | oer, City or Town, | |
| , MD and 2 sho eaith and tem 27 is traumati | Helena Bradle 20a. Method of Disposition | ey Daughter | 20b. Place of D | | | | | Maryland 20c. Location - C | Z Z Z Z Z |
| More Pages I ent of H nt: If it | 1 Burial 2 XCrem 4 Donation 5 Oth | nation 3 Removal from S | Bayview | or other place Cremat | ory | Septe 12, 2 | ember 2008 | Baltimor | e, Maryland |
| Baltimore, permit Pages I and Department of Heal Important: If item injury or other tra | 31. Signature of Funeral Se | | h | 22 Name and Connel 7110 S | Address of Facility Fune: | ral Hon | ne Of 1 | Dundalk, Dundalk, | P.A. Md. 21222 |
| Physician /Medical | 23a. Part I. Enter the diseas failure. List only one of | e, or complications that cause ause on each line. | d the death. Do not e | nter the mode | of dying, such as | cardiac or res | piratory arre | st, shock, or hear | t Approximate Interval Between Onset and |
| xaminer | Immediate Cause (Final dis or condition resulting in dea | | | | | | | | Death |
| 9 | Sequentially list conditions, if any, leading to immediate | | sequence of): | | | | | | |
| led nsit | cause. Enter Underlying Co (Disease or injury that initial events resulting in death). I | ted C | sequence of): | | | | | | |
| 11 = 0 0 | | d | | | | | | | |
| 50, te be exect sysician an burial - tr | UNPENDED IF FEMALE: | AMENDED 23c If we soutce | ome of pregnancy | | | | | 23d. Date of d | elivery |
| box 6876C the death certificate the attending physician for use as the behaviorian physician/Me | 23b. Was decedent pregnan past 12 months? | t in the 1 Live birth 4 Pregnant a | at time of death 5 | Fetal death | | oic pregnancy | | Month | Day Year |
| o.O. Bc that the deended by the zero detached for | | onditions contributing to dea | th but not resulting in | the underlying | g cause given in f | Part I. | 23e. Did tol | bacco use contrib | ute to the cause of death? |
| ords, P.C w requires that as been signed b should be deta | | | | | | | | | Probably 4 Unknown |
| 5 2 20 2 | | | | | _ | | 24a. Was a autops perform | sy pri med? de | ere autopsy findings available or to completion of cause of eath? Yes 2 No |
| Vital Rec ysician: The his certificate director, page | 25. Was case referred to m examiner? | Hospital: | | | 26.Place of Deat | _ | | | |
| of Vigg Physic g Physic ther this neral dir | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of In | iury 28b. Tim | atient 3 l | 28c. Injury at Wo | Nursing Herk? 280 | d. Describe h | Residence 6 V | d |
| ion (tendin leath. A the fur A the fur ation | 1 Natural 5 | Pending FOUND: Sep 8, 2008 | | | 1 Yes 2 | ✓ No Op | erator of i | motorcycle in | collision |
| 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Major Road / Highway 28a. Date of Injury 28b. Time of Injury 2bb. Time o | | | | | | | | | 10, |
| To the Hosp within 24 hos within 24 hos completely fi | 29a. Certifier 1 Certifyi | ng Physician: To the best of r | my knowledge, death | occurred at th | e time, date and p | place, and due | e to the cause | e(s) and manner a | as stated. |
| To the IId within 24 To the Figoration 24 Completel | 29b. Signature and title of co | and manner stated | 1. | | c. License numbe | | e time, date t | | (Month, Day, Year) |
| | aire! 2 | * | | | O.C.M.E. | | | September | 8, 2008 |
| 10 | | erson who completed cause of Assistant Medical Exa | , , | enn Street | Baltimore, MI | D 21201 | | | |
| State | | | ar's Signature | books | -, | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6 9 2008 2:30 p ^M Freddie Burton, Sr Jr. /Medicat 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harfords Gardens Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days **x**M 2□F Director 12-12-1932 218-28-2843 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, I'm Medical Evar, from in ust be regimed at XXYes 2 ☐ No Directo MD N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5107 Darien Road 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2 2 No 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 ∐Yes 2 12 No Specify <u>Ş</u> Black 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: if fleen 27 is marked other than "na any injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th grade College (1-4or 5+) Driver Cab Driver N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann Simmons Freddie Burton, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Burton-Wife 5107 Darien Road Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-10-2008 Baltimore, Greenmount Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H la 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co nsequence of) **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Yea 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □Yes 2 No 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 2V No 1 ☐ Yes After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation death. neral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neath Registrar's Signature 31. Date filed (Month, Day, Year) 32. State frant Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Janice Verice Bossom 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1707 Winford Road N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 6 1918 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 X F Days Hours Months 217-09-0398 Yrs Maryland 90 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1707 Winford Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 XNo Specify Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Union Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard Schaefer Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Bossom - daughter 143 Mallard Lake Drive, Aiken, SC 29803 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/8/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dring 22 Name and Address of Facility Cremation Society of Maryland, Inc. Colly 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Kidney Disease disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 □Yes 2 🗖 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Type 2 DM, COPD, osteoporosis, hypuchclesterclemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 🗆 No 1 □ Yes 2**0** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner requires that the ceath certificate be experted physician and s the burial-trans Box 68760. attending p for use as Ö signed by the the σ. Division of Vital Records, peen certificate has birector, page 2 sl

Examiner Physician/Medical þ Completed To the Hospital or Attending Physician: Be r this c Certification: To After th funeral Within 24 hours after occ...
To the Funeral Director: Aft Medical

Physician

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

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permit. Pages 1 and 2 sh.
Department of Hellith and
Important: If Item 27 is ma

Physician

/Medical

3altimore, Maryland 21215-0036

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

5001 Loch Raven Blvd Year) 31. Date filed (Month, Day, 32. Registrar's Signature

e of death (Item 23a) (Type, Print) #500

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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September 8, 2008

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|--|----------------|--|---|--|--|-------------------------------------|--|---|
| Physicia | | egistrar I. Decedent's Name (First, Middle,La | st) | | | 2. Date of Death | 701 | 1031 hrs |
| edical Exami | | Jacqueline | Barnes | Ab Ciby | Town, or Location o | Month August 28, 2 | 4c. County of Death | 10311115 |
| | | a. Facility Name (if not institution, given 3300 West Forrest Park | | | more | | | |
| Funeral | | 5. Social Security Number 6. S | Sex 7. Age (In yrs. las | | | 100 | MM/DD/YYYY) 9. Birth Foreign | |
| Director | | 213-66-9545 1 | M 2 LF 53 | Yrs. Mont | ns Days Hours | Min. 5.12. | 1955 cou | ntry) MD |
| any | _ <u>_</u> | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Location | | | | 10d. Inside City Limits |
| ž . | اءِ | MD | 5 | altimor | e | | | 1 Yes 2 No |
| Maryland 28a-f show d at once. | Director | 10e. Street and Number | | | p Code | 10g | . Citizen of What Coun | |
| th the Mary 23a or 28a notified at | | 3300 W. Fore | 12. Was Decedent Ever in U.S | | 21216 | gin? (Specify Yes or No- | U.S.A | |
| eath wi items ust be | Funeral | 11. Marital Status 1 Never Married 2 Marrie | Assess Farmer? | If Yes, spec | cify Cuban, Mexican | , Puerto Rican, etc.) | White, etc. | |
| after de | by Fu | 3 Widowed 4 Divorce | ed If Yes, Give Year or Dates: | | 2 C No specify: | | | lack |
| hours : inatura Exami | ed b | 15. Decedent's Education (Specify Elementary/Secondary (0-12) | only highest grade completed) College (1-4 or 5+) | 16a. Decedent's Usua during most of w | al Occupation (Give orking life. DO NOT | kind of work done use retired) | 16b. Kind of Business/Ir | ndustry |
| 136 hin 72 e. than " | ompleted | Elementary/Secondary (0-12) | 2115 | Private | Duty | Nurse 's Name (First, Middle, M | Privat | e |
| 5-0036 led within 72 Hygiene. other than " | ပ | 17. Father's Name (First, Middle, Las | st) | | 18.Mother | 's Name (First, Middle, M | aiden Surname) | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than | Be | Walter Ha | (Type Print | 19b. Mailing Addre | ss (Street and Nur | oorothy C | per, City or Town, State, | , Zip Code) |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygies within 12 hours after death with the Library is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once | 10 | Darryl Thon | ras | 3300 W | . Forest | Park Ave (| | |
| re, N I and FHealth fitem er trau | | 20a. Method of Disposition 1 Burial 2 Cremation | 20b. F | - to to the second | | 0 | | |
| imore Pages I anent of H | | 4 Donation 5 Other Speci | ify: | garrison F | -urest | 9.4.2008 Vaugno C | Baltimo | re, MD |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within longertenent of Health and Mental Hygiene. Important: If tiem 27 is marked other thingury or other traumatic event, the Med | | 21. Signature of Funeral Service Lic | ensee Van co | 22. Name a | nd Address of Facilit | Bultimore | creene for | veral services |
| Physician | | 23a. Part I. Enter the disease, or cor | mplications that caused the death. | . Do not enter the mod | e of dying, such as | cardiac or respiratory arre | st, shock, or heart | Approximate Interval Between Onset and |
| /Medical Examiner | 6 9 | failure. List only one cause on Immediate Cause (Final disease | a. Atherosclerotic Cardiov | ascular Disease | | | | Death |
| - LABITITIES | | or condition resulting in death) | Due to (or as a consequence or | rf): | | | | |
| | Jer | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence o | of): | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequence o | of): | | | | |
| cuted | E E | | d | fh g883 | 0 00 114 | | | |
| O, be exessician | Medical | UNPENDED | AVICTORD | | | | 23d. Date of deliver | |
| ox 68760, anth certificate be executed attending physician and or use as the burial - transit | m/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of preg | gnancy 2 Fetal dea | th 3 Ector | oic pregnancy | | Day Year |
| Box 687: death certificathe attending ped for use as the | Physician/ | 1 Yes 2 No 9 V Unkno | Pregnant at time of de | eath 5 Other (S | ipecify) | | | |
| D. B. trthe de by the | Phy | Part II. Other significant condition | 5 GIRIOWII | resulting in the underly | ring cause given in F | ***** | bacco use contribute to | |
| ires that the signed by | d by | Asthma (clinical history | <i>'</i>) | | | 1 Yes | 2 No 3 Pro | |
| ords, w requir us been s | Completed | | | | | 24a. Was autop | an 24b. Were a sy prior to rmed? death? | utopsy findings available completion of cause of |
| Recc The lay cate ha | I E | | | _ | | | The second secon | es 2 No |
| tal Recition: The certificate | B B | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 | ER/Outpatient 3 | 26.Place of Deat | h (Check only one) Nursing Home 5 | Residence 6 ✔ Othe | er: Scene |
| n of Vir ding Physia After this funeral dir | <u>P</u> | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Wo | | how injury occurred | |
| OD C ending sath. or: Af | 텵 | 1 Natural 5 Pendin | ng | | 1 Yes 2 | | | |
| Division of Vital Records, pital or Attending Physician: The law require unus after death. After this certificate has been si filled in by the funeral director, page 2 should b | Certification: | 2 Accident Investig | not be 28e. Place of Injury - At h | home, farm, street, fac | tory, office building, | etc. 28f. Location (or Town, \$ | | Rural Route Number, City |
| Division of Vital Records, P.O. Box 68760, To the Inospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and completely filled in by the functal director, page 2 should be detached for use as the burial. Tansi | cal Ce | 29a. Certifier 1 Certifying Phy | rsician: To the best of my knowled iner:On the basis of examination | dge, death occurred at | the time, date and | place, and due to the caus | se(s) and manner as sta and place, and due to | ated. the cause(s) |
| To the within To the comp | Medical | 29b. Signature and title of certifier | and manner stated. | 3-1-1 | 29c. License numb | | 29d. Date signed (M | |
| | | Willa Kan | W/m | | O.C.M.E. | | August 29, 200 | 8 |
| J i | | The second secon | who completed cause of death (Ite | m 23a) | | 14D 01001 | | |
| 4 | | ıvıelissa Brassell, MD | Assistant Medical Exam | | Street, Baltimo | ore, MD 21201 | | |
| Regi | State strai | . TE F 11 2 | J ZUUS 32. Registrar's Signa | A AR | E of | | | |
| DUMU 47. D | 1000 | | | OPICINAL | | _ | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** Branch 1:57AM August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner NIA HOSDICE Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Mohth, Day, 0707 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2□ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ita Madical Examinating the notified at once. 1 ☐Yes 2XNo Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA Martair 3507 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of workinglife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Federal Government ecurity 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Collin Trotter Queen Branch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Mayfair Road Baltimore MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Forest 09/04/08 Garrison Ovings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Greeke Funeral Sico 22. Name and Address of Facility Jaugus 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 mos PANCREATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown HYPERTENS ION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 NO 1 ☐ Yes 2 **AN** 1 ☐ Yes ta funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Techner (Specify) 1 | Yes 2 | □ Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA HOSA CE this o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident ☐Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier D0026327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GILY CA 31. Date filed (Month, Day, MD 21045 -OLUMBIA **≜**egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year Shari Baskin 8:02 September 06,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 24,1950 7. Age (In yrs. last birthday) Days Hours Months 219-58-2513 1 □ M 2 🔀 F 58 Brooklyn, N.Y. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Hamill Court 21210 Apt.37 United States of Amer. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Mens Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Samuel Baskin Victoria Debora Rothman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 S. 10th Street Philadelphia, PA. Ken A. Baskin (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State Sept.08, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation 5 Dother (Specify) Page and Address of Facility Page Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses 23a. Part . Enfer the disease, or complications that daused the death. shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final Metastases mauth< disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a amy Injury or other traumatic event, the Wedical Evantment once.

Baltimore, Maryland 21215-0036

the Medical Examinum hast be notified at

Director

Funeral

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Completed

Be

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Examine attending physician and for use as the burial-tran Physician/Medical been signed by the should be detached Completed by certificate has birector, page 2 sl director. Be Medical Certification: To funeral s after death.

i Director: A
d in by the fu

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hain Metastases 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe Yes 2 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

within 24 hours a completely

After this

filled

death.

Hospitai

State Registrar Kendall K H

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Towsentown 32. Registrar's Signature

29b. Signature and title of certifier

State Registrai

DHMH 17 Rev 1/2001

OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

0

2008

Assistant Medical Examiner

32. Registrar's Signature

Margarita Korell MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 1, 2008

Registrar

P.O. I

CHARLOTTE BAKER

Physic /Medi

Regist DHMH 17 Rev 1/2001 **ORIGINAL**

| | 1- For State Registrar | Maryland / D | | iment of He ficate of D | | | 2008 | 28745 |
|-------------------------|--|--|-----------------|--|--------------------------------|--------------------------------------|--------------------------|------------------------------------|
| an | 1. Decedent's Name (First, Middle, Last) | RUTH | ٢ | ZERE | | 2. Date of Death Month | Day Year | 3. Time of Death |
| cal ier | 4a. Facility Name (If not institution, give street and num | , | | b. City, Town, or I | | | 4c. County of Dea | 0.0 |
| | Northwest Hospita | al | | R | andalistow | /n | Ва | altimore |
| | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birtl | N. I. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y | (ear) 9. Bir | rthplace (State or Foreign ountry) |
| | 219.28.4865 | 76 Y | rs. | July Days | | Aug 21, | | WVA |
| | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town | or Locat | tion | | | | 10d. Inside City Limits |
| ៦ | MD Baltimore | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | Reisterstow | rn. | | 1 ☐ Yes 2 ☐ No |
| ect | 10e. Street and Number | | Т | 10f. Zip Code | Zeisteiston | 2. Citizen of What C | country? | |
| Funeral Director | 25 Brookberry : Apt 1C | | | 101. Zip 00dc | , | S.A. | | |
| era | 11 Marital Status 12. Was Dece | dent Ever in U.S. | 13. Wa | s Decedent of His es, specify Cubar | 14. Race - Am | | | |
| 교 | 1 Never Married 2 Married 1 Yes | 2 🚺 No | 1 | | Black, Whi | ite, etc. | | |
| | 3 ☐ Widowed 4 ☐ Divorced If Yes, Given | tes: | 1 1 L | Yes 2₩ No | Specify: | | Specify: W | thite |
| Completed by | 15. Decedent's Education (Specify only highest grade completed) | | | nt's Usual Occupa and of work done do | | king 16 | 6b. Kind of Business | s/Industry |
| ple | Elementary/Secondary (0-12) College (1- | | life. DO | NOT use retired) | aning most or wor | King | | |
| S | | | | | y Worker | | | ry work |
| Be | 17. Father's Name (First, Middle, Last) | _ | | | 18. Mother's Nan | ne (First, Middle, Ma | , | |
| ည | Edward | | | | | | se Castle | |
| | 19a. Informant's Name/Relationship (Type. Print) | | | | | ral Route Number, | City or Town, State, | Zip Code) |
| | Wayne Bere 20a. Method of Disposition | 20b. Place of | | | n raneytow | n, MD 21787 | Oc. Location - City o | r Town State |
| | 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from S | | y, crema | tory or other place | i i | | Ť | |
| | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | Atlar | | ematory, LLO | | 08, 2008 | Glen B | Burnie, MD |
| | NUMBER STATE ROLL TO | Atunen | 3 | Slack Fur | neral Home, | P.A. ke Ellicott City | . MD 21043 | |
| | 23a. Part1. De dise A of complications that ca shock, or heart failur List only one cause on ea | used he death. Do n | ot enter | the mode of dying | , such as cardiad | or respiratory arres | t, | Approximate Interval Between |
| | | LONIC OF | | | | | | Onset and Death |
| | resulting in death) Due to (death) | | | | | | | |
| L | Sequentially list conditions, b. | | | | | | | |
| ine | cause. Enter Underlying Cause (Disease or injury that initiated events C. | ir as a curis quaries u | | | | | | |
| Examiner | that initiated events resulting in death) Last C | or as a consequence o | nf): | | | | | |
| 鱼田田 | | | ,. | | | | | |
| edical | d | | | | | | | |
| N/S | IF FEMALE: 23c. if yes, out | come pf pregnancy | | | | | 23d. Date of de | elivery |
| ciar | in the past 12 months? | rth 2 Fetal death ant at time of death | | ctopic pregnancy Other <i>(specify)</i> | | | Month | Day Year |
| Physician/M | 9 ☐ Unknown 9 ☐ Unkno | wn | | | | | | |
| | Part II. Other significant conditions contributing to de | - | the unde | erlying cause give | n in Part I. | 23e. Did toba | cco use contribute | to the cause of death? |
| Completed by | SCHIZOPHRE | NIA | | | | 1 XYes | 2 □ No 3 □ F | Probably 4 Unknown |
| olet | | | | | | 24a. Was an | 24b. Were a | autopsy findings available |
| mo | | | | | | autopsy perform 1∐ Yes 2 | ed? death? SiNo 1 □Ye | |
| Be C | 25. Was case referred to medical examiner? | | | | 26. Place of Dea | th (Check only one) | | |
| To | | npatient 2 ER/Out | tpatient | 3 DOA Othe | r: 4 ☐ Nursing H | ome 5 Residen | ce 6 □Other (Sp. | ecify) |
| ü | 27. Manner of Death 1 ★Natural 5 Pending (Month | | ime of njury | 28c. Injury Work | at ? | 28d. Describe how | injury occurred | |
| cati | 2 ☐ Accident investigation | | | | ′es 2 □ No | | | |
| ertifi | determined 200. Flace | of injury - At home, far ng, etc. (Specify) | m, stree | t, factory, office | | 28f. Location (Stre City or Town, | | Rural Route Number, |
| alC | 29a. Certifier 1 2 Certifying Physician: To the | best of my knowledge, | , death o | ccurred at the tim | e, date and place | e, and due to the cau | use(s) and manner a | as stated. |
| Medical Certification: | (Check only 2 Medical Examiner: On the ba | isis of examination and | d/or inve | stigation, in my op | pinion, death occu | urred at the time, da | te and place, and du | ue to the cause(s) |
| 2 | 29b. Signature and title of certifier | SW M | מ | 29c. License | | | d. Date signed (Mor | |
| | A worder of | , (| | | 4288 | | Mine o when | 1 5 2008 |
| | | ARAJAN. | Type, Pri | MORTI | HWEST | MEDICA | A CONT | 202 |
| ite | | egistrar's Signature | | | | | | |
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at ange.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> Sta Registra

| | 1 - State Registrar | Certificate of Death Reg. No. 2008 28 | | | | | | | | | | |
|--|--|---------------------------------------|--|-----------------------------|--|-------------------------------|---|--|--|--|--|--|
| | 1. Decedent's Name (First, Middle, Last) | | | n Day Year | 3. Time of Death | | | | | | | |
| an al | Marlene Cecelia Balcera | ak | | | Month August | 29, 2008 | 6:30 pm ^M | | | | | |
| er | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Loc | 4c. County of De | ath | | | | | | | |
| | 206 Larkspur Lane | | Middle Ri | | | Baltimo | re | | | | | |
| | 5. Social Security Number 6. Sex 7. Age (In yrs | | | Under 24 Hrs. Hours Min. | Date of Birth (Month, Day, | Year) (| irthplace (State or Foreign Country) | | | | | |
| | 213-30-5702 75 | Yrs. | | | June 29 | , 1933 M | aryland | | | | | |
| | Usual Residence of Decedent 10a. State 10b. County 10c. C | ity, Town or Lo | cation | | | | 10d. Inside City Limits | | | | | |
| ō | Manual and Dall-danage Mi | | | | | 1 ∐Yes 2∭X No | | | | | | |
| Je C | Maryland Baltimore Mic | ddle Ri | .Ver | | 110 | 10g. Citizen of What Country? | | | | | | |
| Be Completed by Funeral Director | 206 Larkspur Lane | | 21220 | | | U. S. A. | | | | | | |
| Jera | 11. Marital Status 12. Was Decedent Ever in U | J.S. 13. | Was Decedent of Hispa If Yes, specify Cuban, N | anic Origin? (Spe | | | | | | | | |
| 교 | Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No | | | | Rican, etc.) | Black, Wh | | | | | | |
| b | 3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | | 1∐Yes 2XX No S | Specify: | | Specify: | White | | | | | |
| etec | 15. Decedent's Education (Specify only highest grade completed) | | dent's Usual Occupatio kind of work done during | | | 16b. Kind of Busines | s/Industry | | | | | |
| nple | Elementary/Secondary (0-12) College (1-4or 5+) | life. | DO NOT use retired) | ng most of worki | ng | | | | | | | |
| Co | 6 | _ Facto | ory Worker | | | | ufacturing | | | | | |
| | 17. Father's Name (First, Middle, Last) | | 18 | . Mother's Name | (First, Middle, N | Maiden Surname) | | | | | | |
| 2 | Calvin E. Jones | | | Martha | M. Smi | | | | | | | |
| | 19a. Informant's Name/Relationship (Type. Print) | | ng Address (Street and | | | | , , | | | | | |
| | Alan Jones (Brother) 20a. Method of Disposition 20b. | | Galena Ro | <u>ad Balt</u> | timore, | Maryland | | | | | | |
| | ILABunal 2 Li Cremation 3 Li hemoval from State | | osition (Name of matory or other place) | 9/3 | pate 2 | 20c. Location - City of | or rown, State | | | | | |
| | 4 □ Donation 5 □ Other (Specify) Pa. 21. Signature of Funeral Service Licensee | | Cemetery 2. Name and Address of | 2008 | | <u>Parkville</u> | , Maryland | | | | | |
| | 'A | | | | | | | | | | | |
| - | 23a. Part1. Enter the disease, or can pli, at his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | | | | | | | |
| Ш | | ith. Do not en | ter the mode of dying, s | such as cardiac (| or respiratory arre | est, | Approximate Interval Between Onset and Death | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. Acute Myoca resulting in death) | | Infarct | | | | immediate | | | | | |
| | Due to (or as a conse | | | | | | | | | | | |
| er | Sequentially list conditions, if any, leading to immediate | | .sease | | | | years | | | | | |
| min | If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | | | | |
| Exa | resulting in death) Last C. Due to (or as a conse | quence of): | | _ | | | | | | | | |
| Completed by Physician/Medical Examiner | d | | | | | | | | | | | |
| ledi | | | | | | | | | | | | |
| an/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr | nancy | ☐Ectopic pregnancy | | | 23d. Date of d | lelivery | | | | | |
| sicis | 1 Yes 2 No 4 Pregnant at time of | | Other (specify) | | | Month | Day Year | | | | | |
| Phy | 9 LI Unknown | | | | I a au | | | | | | | |
| þ | Part II. Other significant conditions contributing to death but not re Chronic Obstructive Lung Disea: | Ü | nderlying cause given ii | n Part I. | | | to the cause of death? | | | | | |
| ted | CHOICE Obstructive Lung Diseas | se | - | | 1 L Ye | es 2 No 3 | Probably 4X Unknown | | | | | |
| nple | | | | | 24a. Was ar autops | y prior t | autopsy findings available o completion of cause of | | | | | |
| Co | | | | | perform 1 ☐ Yes 2 | | ? es 2□No | | | | | |
| Be | 25. Was case referred to medical examiner? | _ | | | (Check only on | | | | | | | |
| .T | 1X Yes 2 □ No Prospital: 1 □ Inpatient 2 □ 27. Manner of Death 28a. Date of Injury | 28b. Time o | | | | ence 6 Other (S | pecify) | | | | | |
| tion | 1 X Natural 5 □ Pending (Month, Day, Year) | Injury | Work? | 2 No | zau. Describe no | w injury occurred | | | | | | |
| fica | a Doublide 6 D Could not be | ome, farm, str | | - | 28f. Location (St | reet and Number or | Rural Route Number, | | | | | |
| erti | 4 Homicide determined 28e. Place of Injury - At I building, etc. (Spec | ify) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or Town | n, State) | rioral riodio riomosi, | | | | | |
| 29a. Certifier (Check only (C | | | | | | | | | | | | |
| Medical Certification: To | (Check only 2 Medical Examiner: On the basis of examiner) and manner stated. | nvestigation, in my opini | ion, death occurr | red at the time, d | ate and place, and d | ue to the cause(s) | | | | | | |
| Ž | 29b. Signature and title of certifier | | 29c. License nu | | 2 | 9d. Date signed (Mo | nth, Day, Year) | | | | | |
| | ► Ham | | D001 | 6728 | | September | 4, 2008 | | | | | |
| | 30. Name and address of person who completed cause of death (Ite | em 23a) (Type, | Print) | | | | • | | | | | |
| | Dr. Bo Zaw-Win 6830 Hospital | Drive | Suite 104 | Baltim | nore, Ma | ryland 21: | 237 | | | | | |
| te ar | 31. Date filed (Month, Day, Year) SFP 0 9 2008 32 Registrar's Sign | de La | este | | | | | | | | | |
| | State of the state | 1-1 | The state of the s | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State | State | of Mar | yland | • | rtmen <i>rtificat</i> | | | and M | ental Hy | | 000 | 207 | 11 7 |
|-------------|---|--|--|---|------------------|--------------------------|---------------------------|---------------------------|-------------------------|-------------------------------|------------|---------------------------------------|----------------------------|------------------------------|-------------------------------------|----------|
| | _ | | Registrar 1. Decedent's Name (First, Middle | . Last) | | | Cei | lincal | COIL | Jean | | 2. Date of De | ath | 008 | 3. Time of D | Death |
| | Physicia | | James Edward Be | | | | | | | | | Month Septemb | per 4. | 2008 | | Рм |
| | /Medic Examin | | 4a. Facility Name (If not institution | | number) | | | 4b. City, | Town, or | Location o | | - L | | unty of Death | _ | |
| j | | | V.A.Baltimore Re | ehab. Ext | tende | d Car | e Cen | ter | | Balti | | | | | | |
| ŀ | Funeral Director | | 5. Social Security Number 451 40 3064 | 6. Sex 1 M 2 □ F | 7. Age 79 | (In yrs. lasi | t birthday) Yrs. | If Under Months | 1 Year Days | If Under 2 Hours | Min. | 8. Date of Bir (Month, Da March | , 1929 | Cou | place (State or intry) XAS | Foreign |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | | 10c. City, T | Town or Lo | cation | | | | | | | 10d. Inside City | Limits |
| | Aaryla f sho | ō | Maryland Baltin | nore | | Ess | | Julio 11 | | | | | | | 1 ☐ Yes | |
| | the N | rect | 10e. Street and Number | | | | | 10f. Zip | Code | | | | 10g. Citizen | of What Cou | ntry? | |
| | h with | Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 21221 | | | | | | | | | | 1 | USA | | | |
| | ems a | ner | 11. Marital Status | 12. Was De | cedent Ev | er in U.S. | 13. | Nas Deced | dent of H | ispanic Orig | gin? (Spe | cify Yes or No | - 14. | Race - Amer Black, White, | | |
| 30 | or it | by Fu | 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🗗 Divorced | ied 1 🟋 Yes | 2 □ No | 947/60 | | ĭ∐Yes | | Specify: | | | | | ite | |
| 215-0036 | 72 hours after death with the Maryland Inatural", or items 23a or 28a-f show diest Evanther must be mylified at | | 15. Deceden | | Dates: • - | | 16a Decer | dent's Usu | al Occup | ation | - | | 16b. Kind o | of Business/Ir | ndustry | _ |
| 2 2 2 | in 72 | Completed | (Specify only higher Elementary/Secondary (0-12) | st grade completed | d) (1-4or 5+) | | (Give life. L | kind of wo DO NOT u | rk done d se retired | during most f) | of workir | ng | | | | |
| 717 | yd with | Com | 12 | Conege | (1 40/ 01) | | Tru | ack D | rive | | | | | n Carr | ier | |
| yland | be file | Be | 17. Father's Name (First, Middle, | Last) | | | | | | | | (First, Middle, | Maiden Sur | rname) | | |
| 2 | hould d Mer marke matic | မ | Herman B. Beyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town | | | | | | | | wm State 7 | in Cada) | | | | |
| <u>∞</u> | od 2 s Ilth an 27 is u | | Cathy Hanlin (Pe | | Rep.) | | | • | , | | | timore, | - | | | |
| ē, | s 1 ar | 1 3 | 20a. Method of Disposition | | | 20b. Plac | e of Dispo | sition (Nai | ne of | - | | ate | | ion - City or T | | |
| Ē | Page nent c ant; if ury or | | 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S | | m State | | riew (| | | | /5/2 | 800 | Balti | more, | Marylan | ıd |
| Baitimore | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it all fedical Evantment must be inviting any once. | | 21. Signature of funeral Service | Licensee D | usb | | B1 | Name ar CUZOZ 407 O | id Addres | ss of Facility 1 Fundaster | eral | Home I | P.A. | Marvla | nd 2122 | 1 |
| | | | 23a. Part . Enter the disease, or shock, or heart failure. List | complications tha | t caused the | he death. | | | | | | | | | Approximate Interval Betw | |
| 7.4 | Physician | e d | Immediate Cause (Final disease or condition | | | | uctiv | e Pul | mona | ary Di | seas | e | | 1 | Onset and D | |
| and' | /Medical Examiner | | resulting in death) | Due t | o (or as a | consequer | nce of): | | | | | | | | | |
| | - xammer | <u>.</u> | Sequentially list conditions, | b | o for on o | conse uer | non offi | | | | | | | | | |
| | nsit | mine | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events | Dile | o (or as a | consequer | ice ort | | | | | | | | | |
| 2 0 . | exectin and ial-tra | Examiner | that initiated events resulting in death) Last | c Due t | o (or as a | consequer | nce of): | | | | | | | | | |
| 8/60, | icate be executed physician and s the burial-transit | dical | | d | | | | | | | | | | | | |
| | | Med | IF FEMALE: | | | | | | | | | | | | | _ |
| Ž Q | death certific e attending p d for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | | e birth 2 | Fetal de | eath 3[| Ectopic | | у | | | 23d | . Date of deli Month | | ear |
| o. | the de | iysic | 1 □Yes 2 □ No 9 □ Unknown | 9 Un | | time of dea | un 5L | Other (sp | еспу) _ | | | | | | | |
| S, | w requires that the di been signed by the should be detached | by Ph | Part II. Other significant condition | ons contributing to | death but | not resulti | ng in the u | nderlying o | ause giv | en in Part I. | | 23e. Did | obacco use | contribute to | the cause of de | eath? |
| cords | requires that reen signed b | | | | | | | | | | | 1 🔀 | Yes 2□N | No 3□ Pro | obably 4 □ U | nknown |
| ပ္ | law re as be 2 sho | Completed | | | | | | | | | | 24a. Was | | 4b. Were au | topsy findings a ompletion of ca | vailable |
| r | The page | Com | | | | | | | | | | perfo | rmed? | death? | 2 □ No | |
| VItal | Physician: this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | | T Oth | | | (Check only | | | | |
| _ | ding Physician: The law h. After this certificate has funeral director, page 2 s | <u>۲</u> | 1 Yes 2X No 27. Manner of Death | 1 . 11 | Inpatien | t 2 EF | R/Outpatier 8b. Time o | | OA Oth 28c. Injur | 4 E3 Nu | | me 5 Resi | | | cify) | |
| 0 | ndlng th. ; Afte e fune | ation | 1 X Natural 5 ☐ Pendin 2 ☐ Accident investi | g (M | onth, Day, | | Injury | М | Worl | ḱ? Yes 2 🗀 l | | | | | | |
| UIVISION | Atter | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | not be ined 28e. Pla | ce of Injur | y - At home (Specify) | e, farm, str | eet, factor | , office | | : | 28f. Location (| Street and N wn, State) | lumber or Ru | ral Route Numb | oer, |
| 5 | ital or irs afte ral Dii led in | | | | | | | | | | | | | | | |
| | To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | edical | | ng Physician: To t Examiner: On the and m | | examinatio | | | | | | | | | | |
| | vithii To th | Me | 29b. Signature and title of certifie | | | | 1.1 | | | e number | | | | igned (Month | | |
| | | | 1//// | hou | de | | 41 | | D678 | 04 | | | Septe | mber 4 | , 2008 | |
| | 110 | | 30. Name and address of person Andrew Mrowiec 1 | | | | | | Balt | imore | , Mai | cyland | 21218 | | | |
| į | Sta Registr | | 31. Date filed (Month, Day, Year) | 32 | Registrar | 's Signatur | re . | رشهم | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Walter Baxter TEMBER 6 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL ARUNDEL GLEN BURNIE ANNE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 12/27/1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 ☐ F **Funeral** Months Days Hours 375-40-0919 Director 66 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examination, ust by multified at Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1022 Cayer Drive, Apt. 907 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: white þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sergeant U.S. Army permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, If 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter James Baxter Zaida Larkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sally Gonzales / daughter 7698 Early Spring Lane; Severn, MD 21144 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Arlington Nat'l Cem. 9/30/2008 Ft. Meyer, VA 21. Signature of Funeral Service Utenses 22. Name and Address of Facility Singleton Funeral & Cremation de M01411 Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. P vt 1. Enter the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATTAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GASTERO TNIESONM Equeritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed COAGULO PAMY been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) I∐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **⊡**No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTMONE MEDICAL WASHINGTON 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

LAMES

DAYTER,

Registrar's Signature

| 08-06613 | |
|-----------------|--|
| Michael Collier | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Baltimore, M.D. Z.1.Z.19-00.36 Baltimore, M.D. Z.1.Z.19-00.36 4a. Face 4a | cedent's Name (First, Middle,Last chael cility Name (if not institution, givelercy Medical Center cial Security Number 6. Se | Jeffrey | , | Collie | | Reg Date of Death | | 0.7 | |
|--|--|---|-------------------------------------|---|----------------------------------|--|--|--|--|
| Battimore, MD 27275-0036 Battimore, MD 27275-0036 2 1 Director To a 10a. Signature of 11eath and Mental Hygiene To a 28a or 28a-1 show any 10a. Signature of 11eath and Mental Hygiene To Be Completed by Funeral Director To Be C | lercy Medical Center | e street and number) | | COIIIe | r | Month I August 29, | Day Year 2008 | 3. Time of Death 1643 hrs | |
| Director 21 | cial Security Number 6. Se | o da dos da la monisci, | 4 | o. City, Town, or Loca Baltimore | | | 4c. County of De | eath | |
| To Be Completed by Funeral Director | 8-68-5747 _{1X} | 7. Age (In yrs. Ia M 2 F 51 | st birthday) Yrs. | | Hours Min | 8. Date of Birth 08 1 8 | Fo | Birthplace (State or or or or or or or or or or or or or | |
| Permit Pages I and 2 should be filed within 72 hours after death we permit. Pages I and 2 should be filed within 72 hours after death we permit in the permi | | 10c. City, | Town or Location | | | | · | 10d. Inside City Limits 1 X Yes 2 No | |
| Permit Pages I and 2 should be filed within 72 hours after death we permit. Pages I and 2 should be filed within 72 hours after death we permit in the permi | MD NA 10e. Street and Number 711 Mura Street | | | Baltimore 10f. Zip Code 21201 | | | 10g. Citizen of What Country? U • S • A • | | |
| hysician Medical xaminer Seque if any, cause (Disease) (Disease) (Disease) (Disease) | 11. Marrital Status 1 X Never Married 2 Married Armed Forces? 1 Yes X No | | | | | | es or No- 14. Race - American Indian, Black, | | |
| hysician /Medical xaminer January Jan | Decedent's Education (Specify or ementary/Secondary (0-12) th grade | or Dates: | 16a. Decedent | s Usual Occupation st of working life. DO | (Give kind of wo | d) | 16b. Kind of Busine | | |
| 1 X 4 21. Sice land land land land land land land land | 17. Father's Name (First, Middle, Last) Russell Collier | | | 18. Mother's Name (First, Middle Margaret Nea | | | 1 | | |
| 1 X 4 21. Sice 21. Si | Informant's Name/Relationship (Talerie Cornis Method of Disposition | h-Sister | 3412 | Address (Street an Croydon tion (Name of cemete | Road, | | | ld 21207 | |
| hysician /Medical xaminer | Burial 2 Cremation 3 Donation 5 Other Specify ture of Funeral Service Licer | Removal from State | rematory or oth | er place) On | 9/1 | 0/08 | Baltimo | | |
| Medical far Immediate or con Seque if any, cause (Disease events events events and sequents and sequents are sequents and sequents are sequents and sequents are sequents and sequents are sequents and sequents are sequents and sequents are sequents and sequents are sequents are sequents. | Part I. Enter the disease, or comp | Strumpt | 1430 | ame and Address of rch F/H OO Wabas | h Ave. | Balti | more, M | 1d 21215 Approximate Interval | |
| if any, cause (Disea events | failure. List only one cause on ea ediate Cause (Final disease a. ndition resulting in death) | Congestive head Due to (or as a consequence of | art fai | lure | | | | Between Onset and Death | |
| cute In and Itan | nentially list conditions, r, leading to immediate e. Enter Underlying Cause wase or injury that initiated ts resulting in death) Last | Hypertensive of Due to (or as a consequence of Due to (or as a consequence of | ·): | clerotic | cardiova | ascular | disease | | |
| e be execute visician and burial - tra | CUNPENDED d. | AMENDED PI line | | 7, perME, | g885 1 | 1/3/08 | | | |
| the death certificate be executed you the attenting physician and ched for use as the burnal - trans Physician/Medical E. B. A. A. A. A. A. A. A. A. A. A. A. A. A. | MALE: Vas decedent pregnant in the least 12 months? Yes 2 No 9 Unknown | 23c. If yes, outcome of pregritude 1 Live birth 4 Pregnant at time of de | 2 Fe | al death 3 | Ectopic pregnan | су | 23d. Date of del Month | livery Day Year | |
| res that the de signed by the be detached for a by Phy. | II. Other significant conditions | esulting in the u | | | | 3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown | | | |
| Is a national physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed To be a completed to be completed to be completed to be completed. | | | | | | 24a. Was an autopsy performed? 1 ✓ Yes 2 No 2 Yes 2 No | | | |
| ing Physician: The After this certificate funeral director, page SD. To Be Con T X X Y X | 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/Mission by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/Mission by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/Mission by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/Mission by the funeral director, page 2 should be detached for use as the ledical Certification. | Accident Suicide Suici | | | | | | | | |
| To the Hospital or Attend within 24 hours after death within 24 hours after death completely filled in by the Medical Certification (a) (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | Homicide determine Certifier 1 Certifying Physic 2 Medical Examine | tian: To the best of my knowled | ge, death occur nd/or investigat | red at the time, date | and place, and death occurred at | due to the cause | e(s) and manner as | stated. to the cause(s) | |
| 29b. S | Signature and title of certifier Four M | and manner stated. | - | 29c. License n | | | 29d. Date signed August 30, 20 | (Month, Day, Year) | |
| ₩ Ta | ame and address of person who asha Greenberg MD. Date filed (Month, Day, Year) | completed cause of death (Item Assistant Medical Exam | iner 111 | Penn Street, Ba | altimore, MD | 21201 | | | |

DHMH 17 Rev 1/2001 OCME 2006

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21213 20c. Location - City or Town, State Owings Mills, MD East F/H Balto, 21202 MD Approximate Interval Between Onset and Death To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 🔭 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) timore MD21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

Black

Methodist

Church

10d. Inside City Limits

1 Yes 2 No

9:40 pM

MD

2008

A

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Qay **Physician** Month Year PUIVIA 11:46AM /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Joseph Medical Inwann 7. Age (In yrs. last birthday)
Yrs. If Under 24 Hrs. If Under 1 Year Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) **Funeral** Days -34-832 Hours Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to notified at 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? Street and Number 10f. Zip Code Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 XNo Specify: ģ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retized) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) er's Name (First, Middle, Last) Be ဂ္ Informan's Name/Relationship (7) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method on Disposition

Burial 2 □ Cremation 3 □ R

Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ch as cardiac or respiratory arrest. Immediate Cause (Final **Physician** VENTRICULAR RIGHT FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FULMONARY EMBOLUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transi Box 68760, 8 Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the ar P.O. 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ LEFT CEREBELLAR INFARCT 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate 2 □No 1 □Yes 2 **X** No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ∐Yes 2 XNo 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 X Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE.

7601

32. Registrar's Signature

29c. License number

D 24034

TOWSON.

29d. Date signed [Month. Dav. Year)

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 7, **Physician** September 6:35 a M Calvin Cormack George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, April 4, **Funeral** Days Year) Hours Months 1 → M 2 □ F Marvland 214-12-1836 89 1919 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar ment be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Glen Arm 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 11630 Glen Arm Road, #112 21057 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Mayes 2 No
If Yes, Give 143-146
Year or Dates! 1 ☐ Never Married 2 X Married 1 □Yes 2 🗷 No Specify. Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, it is Medical Examples. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Aircraft Design Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Cormack Welsh Alfred ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11630 Glen Arm Rd., Glen Arm, MD 21057 Martha Rose Cormack-wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 9/12/08 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau G. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

Division of Vital Records, P.O. Box 68760 GEORGE CORMACK

a.m.

6:35

SEPTEMBER

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral To the within To the

oH State

DR. ERNESTINE WRIGHT 31. Date filed (Month, Day, Year) SEP 0 9 2008 Registrar

29b. Signature and title of certifier

1 X Natural 2 ☐ Accident

3 Suicide

29a, Certifier

Medical

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be

determined

2300 DULANEY VALLEY RD. 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

com ben

1 ☐ Yes 2 ☐ No

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Опми 17 Rev 1/2001 ОСМЕ 2006

State Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Russell Alexander MD

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DOME

September 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Эм nmina 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Janka 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex ast birthday **Funeral** Min. 250-24-0384 Days 1 □ M 2 12 XE Months Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 28a-f show 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f shov Examiner must be notified at 1 Xes 2 No Director Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Completed by 3 Widowed 4 Divorced "natural" of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, I'm Meximuse." 12 man College (1-4or 5+ Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address /Street and Number or Rural Route Number, City or Town, State, Zip Code) Friend mille Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ı la 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility 21229 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner to (or as a consequence of The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 20 No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the sahould be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an cate has page 2 s autopsy certificate of Vital 1 ☐ Yes 2 **X**No or Attending Physician; director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) solo mon mi 229 31. Date filed (Month, Day, Year) 9 2008 Registrar's State Registrar

DERRICK

Division or Vital Records, Hospital

within 24 hours a the

Medical

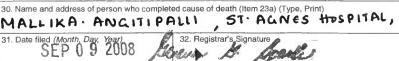
MALLIKA · ANGITI PALLI 31. Date filed (Month, Day, SEP 0 9 State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Mallina. A



M·D

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

900 S. CATON AVENUE MD-21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 2008 13:43 PM Lee Connor dward 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1788 Richfield Drive Anne Arundel Severn 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 4–28–1933 7. Age (In yrs. last birthday) **Funeral** 1 1 2 M 2 □ F Months Days Hours Director 219-28-8426 75 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Exercitor roust by notified at 1 ☐ Yes 2X No Funeral Director MD Anne Arundel Severn 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1788 Richfield Drive 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: African American Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Completed by 3 N Widowed 4 □ Divorced "natural", other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental F Important: If item 27 is marked ott eny injury or other traumatic even once. Be Charles William Connor Roxie Skates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Leslie Addison/daughter 1841 Quebec St.; Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets Cem. 9-9-2008 Crownsville, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation 101411 Services; 1 2nd Ave SW; Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe Immediate Cause (Final disease or condition resulting in death) sophagea. April, 2008 Physician /Medical Due to (or as a conse uence of) Examiner Sequentially list conditions, if any, leading to minimize date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ormeo? 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09/05/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEI TANG M.P. 10 N. Greene St 21201 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 2008 Registrar

| | | State Registrar 1. Decedent's Name | e (First Midd | le Last) | | | | ertificate of | Deam | 2. Date of Dea | Reg. No | 008 | 3. Time of De |
|--|--|--|--|--|--|--|---|--|---|---|--|--|--|
| ician | 3 | JENNETTE | | | | | | | | Month AUG. | Day 26, | Year 2008 | |
| dical niner | | 4a. Facility Name (I | | | et and num | ber) | | 4b. City, Town, | or Location of Deat | | - | nty of Dea | |
| | | JOSEPH R | ICHEY : | HOSPI | CE | | | BALTIM | | | | | |
| al | 1 | 5. Social Security N | | 6. Sex 1 ☐ M | 2 X F | | rs. last birthda Yrs. | Months Day: | | . (Month, Da | y, Year) | Co | thplace (State or Fo ountry) |
| or | - | 301-52-5 Usual Residence of | | | | 58 | } | | JAN. 3 | 1, 1950 | OH | | |
| | | 10a. State | 10b. County | | | 10c. | City, Town or | Location | | | | | |
| Director | | MD | MONT | GOMER | Y | RC | CKVILL | E | | | | | |
| i i | | 10e. Street and Nur | mber | | | | 10f. Zip Code | | | | 10g. Citizen of What Co | | |
| by Funeral Director | e a | 14929 BR | RADWILL | | Was Deced | lant Consin | 110 | 20850 | Hispanic Origin? (| Careity Von or No | USA | Dana Ami | erican Indian, |
| III III | | Marital Status Never Marri | ied 2□ Mar | | Armed Ford | ces? | 0.5. | If Yes, specify Cu | ıban, Mexican, Puer | to Rican, etc.) | | Black, Whit | e, etc. |
| 2 | 2 | 3 ☐ Widowed | | | If Yes, Give Year or Da | e | | 1 □Yes 2 🔼 N | o Specify: | | Spe | ecify: Wh | HITE |
| Completed | bele | (Sner | 15. Deceder | nt's Educati | on omnleted) | | 16a. De | cedent's Usual Occ | upation | erkina . | 16b. Kind of | f Business | /Industry |
| | | Elementary/Seco | ondary (0-12) | | College (1- | 4or 5+) | 1 | | e during most of wo red) | , King | | _ | |
| S | | 12T | | (act) | | | HO | MEMAKER HO 18. Mother's Name (First, Middle, Maiden Su | | | | _ | |
| a a | ן מ | | | | | | | | | OU KITTS | | iamej | |
| once. To Be Completed by F | ≚ - | HAROLD CURTIS DEAN 19a. Informant's Name/Relationship (Type. Print) 19b. March 19b. Ma | | | | | ailing Address (Stre | et and Number or R | | | wn. State. | Zip Code) | |
| | | HEATHER | | | | | 1 | , | WILL CT., | | | | |
| | | 20a. Method of Dis | position | | | | . Place of Dis | sposition (Name of rematory or other p | 1 | Date | | | Town, State |
| | | 1 ☐ Burial 2 I 4 ☐ Donation | | | oval from S | tate / | | RDENT | | 30/2008 | HANOV | ÆR. N | MD |
| ouce. | | 21. Signature of Fu | uneral Service | Licensee | 2// | | , | 22. Name and Add | ress of Facility WE | SLEY CHA | VIS, J | R. FI | VRL. HM. |
| а | | _ | Isle | 1 | 16 . | * 17 | | | | | | | |
| | | | 1 | 4 | lar | - W | | 2007-09 | EASTERN | | | E, MD | 21231 |
| n | | Immediate Cause disease or condition | (Final | complicat t only one o | ions that ca | u er the de | eath. Do not e | 2007-09 | | | | E, MD | 21231 Approximate Interval Between |
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gropm

JENNETTE CHRISTTE -8/26/08

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 28758 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 6 2008 D'Onofrio Bettylee Н 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4724 Meise Drive Baltimore Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year) May 11 1943 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1□ M 2□ F Days Hours Min. Baltimore, Maryland 217 40 1693 65 Yrs Director Usual Residence of Decedent death with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shov Director 1 ☐ Yes 2 ☑ No Baltimore County Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4724 Meise Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛛 No ı ıs marked other than "natural", or items traumatic event, السيريات الاسترام 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates: Completed by 1 ☐ Yes 2 ☐ **X**No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) Clerk USF8G Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William W Mangels Margaret David ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once. 4724 Meise Drive Baltimore, Maryland 21206 Ronald A D'Onofrio (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery September 11 2008 Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Licensee 7401 Belair Road Baltimore Maryland 21236 23a. Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examine physician and the burial-transi law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown à cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting, in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of las autopsy death? 1 ☐ Yes certificate perforn 2 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes Other: 4 Nursing Home 5 Besidence this 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) Certification: To After th funeral 27. Manne f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation hours after death. 1 ☐ Yes 2 ☐ No Director: Accident 3 ☐ Suicide 6 ☐ Could no be To the Hc.
within 24 hours
To the Funeral Dn. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) detern 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of contiffe on who completed cause of death (Item 23a) (Type, Print) 30. Name and address 21204 Towson, Maryland 7505 Osler DR. John Downs 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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| Be Co | 17. Father's Name | (First, Middle, | Last) | | | | . US AK | 1 | s Name | (First, Middle | e, Maiden S | | 11(1 |
| 일 | SIMEON | DUNCAN | | | | | | \ v : | IRGI | NIA FO | RD | | |
| | 19a. Informant's N | ame/Relations | ship (Type. | Print) | | 19b. Mailing | g Address (Stree | t and Number | or Rura | l Route Num | ber, City or | Town, State, Z | ip Code) |
| | SYLVIA | | /NIECI | Ξ | 20h Bio | | WATT AV | /E. APT | | L SACR | | O, CA | |
| | 20a. Method of Dis 1 Burial 2 | Cremation | | oval from Sta | te ce. | metery, crem | natory or other pla | i | | | | ation - City or 1 | |
| வி | 4 Donation 5 Other (Specify) ARLINGTON NATIONAL 9-16-08 ARLINGTON, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SO | | | | | | | | | | | | |
| ouc | 1 Oan | James 9. Morton 1701-31 LAURENS ST. BALTIMORE, MD 21217 | | | | | | | | | | | |
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State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:50 a_M Ruth Vivian Eid Ε. September 5, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 113 Bloomsberry Street Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 3/31/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-20-0749 1 M 2 KF 83 MD Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show MD Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Bloomsberry Street 21230 USA 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo ─If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2XNo Specify à Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Harnsberger Elizabeth Marie Egner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Bloomsberry Street, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra Linda E. Braun / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/9/2008 Cedar Hill Cemetery Glen Burnie, MD 21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1etas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by erioscleratic Cardiarmenta D 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 26203 2008 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

lecillo

31. Date filed (Month, Day, Year)

SEP 0 9 2008

2. Registrar's Signature

. Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Day **Physician** Mildred ам Eades 4 2008 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Towson Balto 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🂢 F Months 213-22-2166 Director 11-12-1925 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified an once. XXYes 2□No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 542 McMechen Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3XXVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 12th grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Parker ည Katherine Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Jones-Daughter 1552 Upshire Road Balto, MD 21218 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State x Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 9-8-2008 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H Warren 1101 E. North Avenue Balto, MD_{\perp} 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 1 □ Yes 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760 P.0. Vital Records. ospital or Attending Physician: hours after death. Division of within 24 hours a

To the Funeral C

completely filled

a.m.

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

DR.

(Check only one)

31. Date filed (Month, Day,

SEP 0

29b. Signature and title of certifier

TARIQ MAHMOOD

9

Medical

2300 DULANEY VALLEY RD.

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

LOX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28763 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** 1031 PM 2008 Ronald W. Epps /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours NDM 2□F 60 Director 27 05 48 MD 218-44-7130 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 D partment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 are not by injury or other traumatic event, the Medical Enginese must be one. 1222 Roesiter Ave Apt 1A 21239 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2∐XVo Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Security Guard Bankers Corp na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Edith Ralley William Epps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 362 Maydell Road, Baltimore, md Timothy Epps-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion 9/12/08 Baltimore, Md 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West Small 21215 4300 Wabash Ave, Baltimore, Md 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final **Physician** a ACUTE MYDIAL INFARCTION disc se or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATHEROSCLEROTIC CAPDIONASCULAR DISEAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760; Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No Division of Vital Records. P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Hospital: ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 29c. License number M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH PAVEN BUYD BALTIMORE KERITH JOSEPH M.D. 31. Date filed (Month, Day, Registrar's Signature State 09 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 2008 **Physician** 8:15 pM Clarence Elwood Elliott /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Beltsville 4810 Odell Road Birthplace (State or Foreign Country)
 TTP If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ★ M 2 □ F 27,1928 July 228-28-7298 80 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nedical Expressions to use to notified at 1 ☐ Yes 2√12 No Directo Beltsville Prince George MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Department of Health and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2. any injury or other traumatic event, the Mantana and once. USA 20705 4810 Odell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 QYes 2 No 1946− If Yes, Give Year or Dates: 70 1 ☐ Never Married 2 ☑ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Combat Engineer U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4810 Odell Road, Beltsville, MD 20705 Brunhilde S. Elliott/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 23, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 2008 Arlington Nat.Cem. 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Joken Stile 313 Talbott Ave., Laurel, MD 20707 M01053 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2.5 months Physician Gastric cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for tree as the burneral completely filled in by the funeral director, page 2 should be detached for tree as the burneral completely filled in by the funeral director, page 2 should be detached for tree as the burneral completely filled in by the funeral director, page 2 should be detached for the same and the completely filled in by the funeral director. Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 8,2008 sum mo MD31449 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura L. Sessums, MD, WRAMC, 6900 Georgia Ave., NW, Washington, DC 20307 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 09 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 5 2008 **Physician** 12:52 p M Mary Blaise Fusting /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Buchanan Road Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 66 Maryland Director 219-42-5783 Feb 3, 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Experience must be redified at Director 1 ☐ Yes 2X No Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Buchanan Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important if item 27 is marked other than any Injury or other framewise. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Moore Una Mullan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Fusting, Jr. / Hus 6 Buchanan Rd. Baltimore, Md. 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dualney Valley Mem. 9-11-08 Timonium, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fund al Serrice Licenses Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ducerse disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₫ res 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 2 Z No 1 ☐ Yes 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year)

State Registrar TREOGIL

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

TITMO, 6301 NCHALLES ST, BAUTIMOLE, MD 21212

person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

W IGLERAMIT

Year)

9 2008

2008

10a. State

MD

Certificate of Death

4c. County of Death

| Physician |
|-----------|
| /Medical |
| Examiner |

1. Decedent's Name (First, Middle, Last) George W. Fowler, Sr.

Baltimore

4a. Facility Name (If not institution, give street and number)

10b. County

2. Date of Death Month Day Year September 5, 2008

3. Time of Death 5:00 A M

10d. Inside City Limits

1 ☐ Yes XXNo

Keswick MultiCare Center Social Security Number 212-28-5279 Usual Residence of Decedent

7. Age (In yrs. last birthday) Yrs

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 29,

4b. City, Town, or Location of Death

Baltimore

 Birthplace (State or Foreign Country) MĎ

Funeral Director

death with the Maryland

Baltimore, Maryland 21215-0036

d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director Funeral Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite Lry or other traumatic event, the Medical Examines. þ Completed Be (

Department of Important: If any Injury or

Physician

/Medical

Examiner

sician and burial-tran

nse

ed by the atter detached for u

The law requires that the death certificate be executed

or Attending Physician:

the Hospital

Division or Vital Records, P.O. Box 68760,

10c. City, Town or Location

77

Lutherville

10g. Citizen of What Country?

10f. Zip Code 21093

U.S.A.

11 Marital Status 1 Never Married 2 Married

10e. Street and Number

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1960

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 💢 💥 o Specify

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

3 Widowed 4 X vivorced

8716 Valleyfield Rd

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Agent

16b. Kind of Business/Industry

Glen Burnie, MD

12+

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) Lillian Bell

Ratheon

George Hand Fowler

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Valerie Derry (Daughter)

8716 Valleyfield Rd Lutherville, MD

20a. Method of Disposition

1 ☐ Burial 2 ▼ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory

Date 20c. Location - City or Town, State

21. Signature of Funeral Service Acenses

22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, 1nc.
3631 Falls Road Balto, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Due to (or as a consequence of)

Due to for as a consequence of

Dunderal

Due to (or as a consequence of)

Approximate Interval Between Onset and Death 9 mb H S

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? I□Yes 2□No 9 🗌 Unknown

23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

adehocarcinoma

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Orderoscleroscie Cardishascular

2 No 3 Probably 4 Unknown 1 Tes 24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Completed by Physician/Medical Be 25. Was case referred to medical examiner? 1 Yes 2 100 Certification: To

27. Man of Death

2 T Accident

3□ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier M. Babelle Mac

September 8,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRBELLE MACGREGOR OR, 700 W. 40 TH STREET, BALTIDORE, DO 21211
32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

Medical

SEP 0 9 2008



within 24 hours after dea To the Funeral Director completely filled in by th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06745 State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH g883 Certificate of Death Robert George Fuchs 2008 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day September 3, 2008 1056 hrs **Medical Examiner** Robert George Fuchs 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Sparrows Point **Baltimore County** 1430 Sparrows Point Blvd 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours Feb.28,1943 Director 218-40-8352 Country) MD 1X M 2 F 65 Yrs Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f show notified at once. MD Baltimore Baltimore Director hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7922 Bank Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 X Married 1 X Yes 9 White Yes, Give Year Specify: 3 · Widowed 4 Divorced Yes 2 X No specify: "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Severstal 72 the Medical Dockman Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. 12th International marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Frederick Fuchs Margaret Regina Shine
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ip Code) 19a. Informant's Name/Relationship (Type, Print) other traumatic Janet Fuchs /wife 7922 Bank Street Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Bayview Crematory Baltimore MD Burjah 2 X Cremation 3 Removal from State 108/08 mportant: Concition 5 Other Specify Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Essex 21221
eart Approximate interval Connelly Funeral. Home of s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complica **Physician** Between Onset and failure. List only one cause on each line /Medical Death Chest Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed and Physician/Medical AMENDED UNPENDED attending physician or use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Dav Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O certificate has been signed by ector, page 2 should be detach ð Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records. 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✔ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Subject was pushed off ramp by a large amount Certification Sep 3, 2008 1034 hrs Natura 1 ✔ Yes 2 Pending of cinder into wall completely filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 1430 Sparrows Point Blvd, Sparrows Point, MD determined (Specify) Industrial Area Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E September 4, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Lina Li, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

2008

09

32. Registrar's Signature

E ROLLES

Saltimore, Maryland 21215-0036

within 24 hours a

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Flowers September 09:54AM 4rts 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balthmore Bayview Medical Center Johns Hopkins If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 XM 2□ F Days Months 7-18-1938 NC 219-26-5704 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tyes 2 □ No Director BALTIMORE TURNER STATION 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 127 SOLLERS POINT ROAD 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify þ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL COMPANY 12 ADHESIVE WORKER 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) MYRTLE LOMAX NATHANIEL FLOWERS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 SOLLERS POINT RD. BALTIMORE, MD IMOGENE FLOWERS/WIFE permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 9-13-08 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD ames totton 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart disease or condition resulting in death) Due to (or as a consequence of): Myocardi 21 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifiei 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES - 000 september 07,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore MD orrel Brown 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year SHARON DARLENE FREEMAN-DAVIS 4:50 PM 2008 AUG. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 604 GRAIN CT., ANNE ARUNDEL E. MILLERSVILLE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🕏 F Yrs. 220-64-1080 JUNE 11, 1957 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 1626 DARLEY AVE. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Specify: BLACK If Yes, Give Year or Dates 1 ☐Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES B. FREEMAN SHIRLEY R. FREEMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHAREESE KESS-LEWIS/DAUGHTER 604 GRAIN CT., E., MILLERSVILLE, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5500 O DONNELL ST. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/16/2008 BALTIMORE, MD 21224 TRINITY 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final M disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any cause are underlying cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a nonsequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 2 □ No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) \(\frac{\text{Amesidence}}{\text{Thesidence}} \) \(\frac{\text{6\text{Nursing Home}}}{\text{Thesidence}} \) \(\frac{\text{6\text{Nursing Home}}}{\text{Thesidence}} \) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

Be ဥ

d other than "natural", or items 23a or 28a-f shov event, the Medical Examinar must be notified at

7 Is marked other traumatic event. If

Department of Health Important: If item 27 any injury or other trong once.

Health a

Physician

/Medical

Examiner

cate has been signed by the attending physician and page 2 should be detached for use as the burlal-tran

funeral director,

the

filled in by

completely

After this

death

within 24 hours after death To the Funeral Director:

Physician/Medical Examiner

ş

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a State

MD

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending

> State Registrar

29c. License number

tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

D47934

PL BARMONE MD 21202

AUGUST 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VEOMMS

22 57

31. Date filed (Month, Day, Year) 32 egistrar's Signature SEP 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 5 **Physician** 2008 **JEANETTE** FRIEDEL 9:15 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE BRIGHTON GARDENS OF PIKESVILLE PIKESVILLE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 217-05-9727 **Funeral** 1 □ M 2 □ X F Months Days Min. Hours 1470171912 95 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If lieue 72 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. "A death Exc." 1 □Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1840 REISTERSTOWN ROAD 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No ģ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAVETMAN HARRY SNEIDER ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD FRIEDEL / SON 219 NORTHWAY , BALTIMORE, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 09/07/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final disease or condition resulting in death) **Physician** 6-260 MO 2014 / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed P.O. Box 68760, Due to (or as a consequence of) signed by the attending physician the detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 other (Specify) ASSISTED 1∐Yes 2⊟No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 d Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLASSON UPRRYCAKE DI. 3AL 2700 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

VEANETTE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** LVVU 2608 /Medical 4a. Facility Name (If hot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Secours HOSPITA BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 215-70-3046 1**X** M 2□ F Months Days Hours Min. Director 26, 1957 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'ms I'ms dien Evertinet must be notified at once. 10d. Inside City Limits 10b. County 10c. Sity, Town or Location 10a. State MD 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2126 USA 50 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: þ 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH CUSTODIAN CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ JOHN GARDNER LAURETTA SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 MARTINGALE AVE., BALTIMORE, MD LATARSHIA GARDNER/DAUGHTER 21229 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 5-08 4 ☐ Donation 5 ☐ Other (Specify) HANOVER, MD ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231 complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. 23a. art 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 122 Dry disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2) No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records, funeral director, After

within 24 hours after deatl To the Funeral Director:

27. Manner of Death

f Natural

2 ☐ Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

29a. Certifier (Check only one) 5 Pending investigation

6 Could not be determined

| 7 | |
|---------|----|
| Sta | |
| Registr | ar |

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 09 2008 SEP

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

12 Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes

2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

0

| | State Registrar | | | Ce | rtificate of L | Death | Re | g. No.2 () (| 80 | 28772 |
|--|---|--|--|--|--|--|--|--|--|--|
| an | 1. Decedent's Name (First, Middle | le, Last) | | | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
| cal | HATTIE | ELIZABET | | | | | Septembe | | 800 | 11:28am ^M |
| er | 4a. Facility Name (If not institutio | | ımber) | | 4b. City, Town, or | | | 4c. County o | | |
| | GOOD SAMARITAN 5. Social Security Number | HOSPITAL 6. Sex | 7. Age (In yrs. | last birthdav) | BALTIMO If Under 1 Year | ORE If Under 24 Hrs. | 8. Date of Birth | N/A | | lace (State or Foreign |
| | 213-36-7169 | 1 □ M 2 XX F | 68 | Yrs. | Months Days | Hours Min. | (Month, Day, NOV • 10 | | Coun | |
| | Usual Residence of Decedent | | | | | | INOV. 10 | 1,000 | | |
| _ | 10a. State 10b. County | | 10c. City | y, Town or Lo | ocation | | | | 1 | 0d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| Director | MARYLAND N/ | 'A | | BA | LTIMORE | | T | | | |
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| | 1241 N. CURL | | edent Ever in U. | 9 13 | Was Decedent of Hi | 213 | pecify Yes or No- | | | an Indian, |
| Laiciai | 11. Marital Status 1XXNever Married 2 ☐ Mar | Armed Fo | orces? | 3. | If Yes, specify Cuba | n, Mexican, Puerto | Rican, etc.) | | , White, | |
| 5 | 3 ☐ Widowed 4 ☐ Divorced | If Yes G | ive | | 1 □Yes 2 🗓 No | Specify: | | Specify: | BLA | ACK |
| 2 | 15. Deceder | nt's Education est grade completed) | | | dent's Usual Occupa | | | 6b. Kind of Bus | siness/tno | dustry |
| Completed | Elementary/Secondary (0-12) | College (| | life. | DO NOT use retired, | uning most of work | (iiig | | | |
| | 12th grade | | | POST | AL WORKER | | | US POS | | FICE |
| 3 | 17. Father's Name (First, Middle, | Last) | | | | | ne (First, Middle, M. | | ?) | |
| 2 | SOLOMON HILL | T | | | ANN BRIG | | | 0.1.) | | |
| | 19a. Informant's Name/Relations | | | | ng Address (Street a | | | | | |
| ŀ | Marlon E. Hill 20a. Method of Disposition | ./SON | 20b. P | | N. Curle | * | | Oc. Location - 0 | | |
| | 1 X Burial 2 ☐ Cremation | | State | emetery, cre | matory or other place | 1 | | | - | |
| | 4 Donation 5 Other (S | | OAI | | CEMETERY 2. Name and Addres | | 11-08 | ESSEX, | | |
| | Pastan (| Kron | n / | | 2. Name and Addres ILLIAM C 206 W NOR | | | 'UNERAL | HOM | E P.A. |
| | , [| Approximate Interval Between | | | | | | | | |
| | shock, or heart failure. List Immediate Cause (Final disease or condition | only one cause on | ogn line. | 1/e. | MADEA | - dirl | INT. | - di | ~ | Onset and Death |
| | disease or condition resulting in death) | a | (or as a consequ | | / | | | | - 3 | |
| | | | | | | | | | | |
| 놂ㅣ | Sequentially list conditions, It is the first of the conditions, Cause. Enter Underlying Cause (Disease or injury | | | | | | | | | |
| Ĕ | cause. Enter Underlying | | | | | | | | | |
| 1 | triat initiated events | с | | | | | | | | |
| | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | (or as a consequ | uence of): | | | | | | |
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the trincater present director and 2 should be detected by the state of the buriet transfer.

| | 1 - For State Registrar 1. Decedent's Name | /Einnt 2011 | (ant) | | Cei | rtificate of E | Death | 2. Date of De | | .20 | 3.0 | - | 87 | | | | |
|--|---|---|---------------------------------|----------------------------|--|---|--|---|--------------------|------------------|---|---|------------|-------------|--|--|--|
| 1 | Charles | | | | | | | Month | Da | | Year | | ime of D | | | | |
| <u> </u> | | | give street and numbe | er) | | 4b. City, Town, or | Location of Deat | Septeml | 40 | 5, 2 . County | of Dea | th | :06 | ٢ | | | |
| | 14218 Gr | | | | | Baldwin | | | | Balt | | | | | | | |
| | 5. Social Security Nu 215-44-040 Usual Residence of I | 66 | 6. Sex 1 ☐ MM 2 ☐ F | Age (In yrs. la | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birl Month, Da 7/9/19 | th y Year 55 |) | 9. Bir Co Mai | thplace (ountry) rylar | State or . | For | | | |
| Ì | | 10b. County | | 10c. City, | , Town or Lo | cation | | | | | | 10d. lns | side City | Lir | | | |
| חוברוח | MD Baltimore Baldwin | | | | | | | | | | | 1 [| ☐Yes 2 | <u> </u> | | | |
| | 10e. Street and Num 14218 Gree | | ſ | | | 10f. Zip Code 21 01 3 | | | 10g. C | itizen of V A | What Co | ountry? | | | | | |
| מונום | 11. Marital Status | | 12. Was Deceder Armed Forces | 5? | 3. 13. | Was Decedent of His f Yes, specify Cubar | spanic Origin? (S n, Mexican, Puert | Specify Yes or No to Rican, etc.) | - | | e - Ame | erican Ind | lian, | | | | |
| <u>~</u> | 1 ☐ Never Marrie 3 ☐ Widowed 4 | | | Mo | 1 | I∐Yes 2∐XNo | Specify: | . , | Lagran . | Specify | | hite | | | | | |
| בונו | (Special | 15. Decedent's fy only highest | Education grade completed) | 1 | (Give | dent's Usual Occupa kind of work done di | uring most of wor | king | 16b. F | Kind of B | usiness | /Industry | | | | | |
| naialdilloo | Elementary/Secon | dary (0-12) | College (1-4o | r 5+) | Farme: | 00 NOT use retired) r | | | Αc | gricu | ıltu | re | | | | | |
| 5 | 17. Father's Name (F | First, Middle, La | ast) | | | | 18. Mother's Nan | ne (First, Middle, | Maidei | n Surnan | ne) | | | | | | |
| 2 | Gilbert | Hurline | 9 | | | | Lilliar | Sutton | | | | | | | | | |
| ĺ | 19a. Informant's Nar | | | | | g Address <i>(Street a</i> Green Roa | | ural Route Numbe ໂພin, Maງ | | | | |) | | | | |
| | 20a. Method of Dispo | • | | | ace of Disponentery, cren | sition (Name of natory or other place |) | Date | | ocation - | - | | | _ | | | |
| | 1 La Buriai 2 La 4 □ Donation | | 3 □ Removal from Stat ecify) | ° St. | . Jóhn | 's Luther | an 9/9/ | 2008 | | enhei | | - | land | | | | |
| | 21. Signature of Funeral Service Ucorsee 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road | | | | | | | | | | | | ď | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to harmostate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | W | et and De | | | | | |
| no no no no no no no no no no no no no n | IF FEMALE: 23b. Was decedent pin the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown | nonths? | d | 2 ☐ Fetal of at time of de | death 3 | Ectopic pregnancy Other (specify) | | | | 23d. Da Mo | te of de | livery Day | Ye | ar | | | |
| | Part II. Other signific | ant condition | s contributing to death | but not result | ting in the ur | nderlying cause giver | n in Part I. | 23e. Did to | | 7.7 | | | | | | | |
| | | | MOCANO | AL. | ナック | 42 CD U-N | <u> </u> | 101 | es 2 | No | 3□ P | robably | 4 🗌 Un | ikn | | | |
| | | | physe | m | *** | | | 24a. Was autop perfo 1 □ Yes | | - 1 | Were au prior to death? 1 □Yes | utopsy fin completions 2 \(\textsq\) | | /ail .se | | | |
| | 25. Was case referre | ed to medical | | | | | | ath (Check only o | | | | | | | | | |
| | 1 ☐ Yes 2 🕰 | ١٥ | | tient 2 E | | | 4 Li Nursing n | lome 5 Resid | | | | ecify) | | | | | |
| | 27. Manner of Death Natural Accident Suicide Under Homicide | 5 Pending investiga 6 Could no determin | | Day, Year) | 28b. Time of Injury me, farm, stre | Work? | at ? ′es 2 ⊒ No | 28d. Describe h | Street a | nd Numb | | ural Rout | e Numbe | er, | | | |
| | 29a. Certifier 1 (Check only 2 one) | Œ CertifyIng □ Medical E | Physician: To the bes | st of my know | rledge, death | occurred at the tim | e, date and place inion, death occu | e, and due to the | cause(| s) and m | anner a | s stated. | ause(s) | | | | |
| | | | | | | | | | | | /ear) | | | | | | |
| | 1 1 1 1 1 1 | 40 mg. | ンとにかいつ | 111/1 | 1 1/10/ | | /// | 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Anthom Servis no 1235 /orc Al 32c Lutrewice md 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 **Physician** Walter Dane Hammond 2008 6:52 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 01/22/1925 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 218-18-5947 83 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Event party by nothing at Completed by Funeral Director 1 ☐ Yes 2 ☑ No Rosedale MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with tt Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any lijury or other traumatic event 1315 Chesaco Avenue 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Switchboard Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfield Hammond Minnie Bailev ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Graveswood Court, Parkville, MD 21234 Lou Hammond, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Memorial 09/09/2008 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Leonard J. Ruck. Inc. 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC Corncar months /Medical Examiner Proboth melanoms Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate has the irector, page 2 st 24a. Was an autopsy 1 □ Yes 2 🖼 😘 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 6 Other (Specify) (SOLO) 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending investigation Injury nours after death.

neral Director: At 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 🖅 ertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) and title of certifier

Registrar

State

670

Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. CHARLES

32. Registrar's Signature

stendy 5 2008

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 00:30 2008 1) UNN Stewart, Rogers, 4a Fecility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore
H Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Copt. 2, Baltimore University of Manyland Medical Birthplece (State or Goreign Country) 6. Sex. () 1₽ M 2□ F 5. Social Security Number Age (In yrs. lest birthdey) **Funeral** Days Months Yrs. 2008 Maryland NEW E Usuel Residence of Decedent Director permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Depertment of Health and Mentel Hyglene. Important: If item 27 is marked other than "neturel", or items 23s or 28s-f show sany injury or other traumatic event, its Medical Experiment must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Aberdeen Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 21001 15 Newton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo 1 XNever Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0020 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Never Worked 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) Cristin Anne Murtaugh Marc Wayne Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Newton Road, Aberdeen, Maryland, 21001 Marc W. Harrington / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 又Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-8-08 Towson, Maryland Hilltop Service Corp. 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner nonioamni ettending physicien end for use es the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? certificate has been signed by the e irector, page 2 should be deteched i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Tyes To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Medicai Certification: To 1) Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 1 Naturel 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature end title of certifier 10# Hospital 7408 Emily Comgan, MD 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 20 S. Greene Stree MD 2120 , Baltimore

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

0 9 2008

32. Registrer & Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 824 PM 2008 Betty Louise /Medical Horner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale Ballimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1/17/1934 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. 215-30-0607 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, If a Medical Examiner must be notified at Director 1 ☐ Yes 2X No 28a-f Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 21220 U. S. A. 10 Honeycomb Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, I a Magnee. Elementary/Secondary (0-12) College (1-4or 5+) 9 Tax Preparer Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Hunter ပ Grace Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) <u>Charles Joseph Horner</u> 10 Honeycomb Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/ 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, MD Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Physician C. O. P. D disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discussor Light) that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit be executed Due to (or as a consequence of): Box 68760, physician the t attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this funeral 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 Accident 2 🔲 No filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

completely State

Q

DHMH 17 Rev 1/2001

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

LIM

Square

and manner stated.

FRANKLIN

32. Registrar's Signature

La Lin, Mp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DR

29c. License number

RES0000

Baltomd

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Mary F | rancis Ha | vens | tein St | ate of Ma | ryland / | Depart | ment of | Health | and | Mental Hy | /giene | | 200 | 10 | 287 |
|--------|--|--------------|--|----------------------------|----------------------------------|---------------|---------------------------|--|-----------|--|----------------------|-------------------------|-----------------|--------------------|------------------------------------|
| | | 1 | - For State | | | Certi | ficate of | Death | | | | g. No. | | 3. Time of | |
| BA 13 | Physicia | ın/ | Decedent's Name (First, Midd | | ** | | • | | | | Month Septembe | Day | Year | 0853 | |
| Me | ે Examin | | Ma. Facility Name (if not institution | ry Francon, give street ar | ces Ha nd number) | venst | ein / | b. City, To | wn, or Lo | ocation of Death | | 4c. Cou | inty of Death | | |
| | | | 8917 Seven Locks Ri | | | | | Bethes | | | | | tgomery | nlana (C) | oto or |
| | Funeral | | 5. Social Security Number | 6. Sex | _ " | (in yrs. last | birthday) | If Under Months | | If Under 24Hrs Hours Min | _ | | Foreign | 1 | ì |
| | Director | | 219-46-7272 | 1 M 2 | CF | 63 | Yrs | | | | June 2 | 1, 194 | 기 Wast | <u>irngt</u> | on, DC |
| | any | - | Usual Residence of Decedent 10a. State 10b. County | | 1 | 10c. City, To | own or Locati | ion | | | | | $\overline{}$ | | le City Limits |
| | | | Maryland Mon | tgomery | | | | Ве | ethe | esda | | | | | s 2-X No |
| | farylar 28a-f s at on | Director | 10e. Street and Number | -8 | | | | 10f. Zip C | Code | | | | of What Coun | | |
| | a the N 3a or 2 | | 8917 Seven L | | | | | | | 208 | | | ted Sta | | Black |
| | eath with the Maryland items 23a or 28a-f show ust be notified at once. | Funeral | 11. Marital Status 1 Never Married 2 | Married Arm | s Decedent E ned Forces? | | . 13. Wa | is Deceden es, specify | Cuban, | oanic Origin? (S Mexican, Puerto | Rican, etc.) | , , , | White, etc. | an maran | , |
| | 한 등리 | | | 11 vorced If Yes, Gi | ve Year | X No | 1 | Yes 2 | X No | specify: | | Spe | ecify: Wh: | ite | |
| | hours after 'natural''. Examiner | Completed by | 15. Decedent's Education (Sp | or Dates: | | pleted) | 16a. Deceder | nt's Usual C | ccupation | on (Give kind of DO NOT use rel | work done | 16b. Kind | of Business/II | ndustry | |
| • | 72 ho | lete | Elementary/Secondary (0-12 |) Coll | ege (1-4 or 5 | i+) | _ | | | 20 110 1 400 101 | , | | Oran | Home | |
| Š | within giene. | omp | 17. Father's Name (First, Middl | o Last) | 2 | | H | omema | ker 1 | 18.Mother's Nam | e (First, Middle, | Maiden Suri | | HOITE | = |
| 4 | e filed al Hyg | Be C | William She | | | | | | | Emil | y Horni | g | | | |
| 2 | MOIF, MID 21219-UU30 Pages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Montal Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f she and the traumatic event, the Medical Examiner must be notified at once | To E | 19a. Informant's Name/Relation | nship (Type, Prir | | | | | | t and Number or | | | | | |
| : | MD id 2 sh lith and m 27 is | | Cecilia L. Tim | mick/Si | ster | 20h P | 2522 I | | | en Cove, | | 20c. Loca | ation - City or | Town, Sta | 401 |
| | ore, of Hez If iter | | 20a. Method of Disposition 1 X Burial 2 Cremati | on 3 Rem | oval from Sta | ate ArI | rematory or o | ther place). | Lona | 1 Oc | t. 15, 2008 | Arli | ington, | Vir | ginia |
| | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte begartnent of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. | | 4 Donation 5 Other 21. Signature of Funeral Servi | | _ | | | | | | 2006 | 1 77 | , eth | es a- | -Chevy |
| | Departiment of the position of | | | | MO | 00198 | Ro 175 | bert 57 Wi | A. E | of Facility Pumphrey sin Ave | runera Bethe | sda. | e/ MD_208 | ase 3 | inc. 501 _ |
| | Physician | | 23a. Part I. Enter the disease, failure. List only one cau | or complications | that caused | the death. | Do not enter | the mode o | of dying, | such as cardiac | or respiratory at | rest, shuck, | or heart | - Approx | en Onset and |
| 1 | Medical kaminer | | Immediate Cause (Final disea | se a. Multip | le Injunes | | | | | | | | | - | Death |
| | _xammer | her | or condition resulting in death |) Due to (| or as a conse | equence of |): | | | | | | | | |
| | | | Sequentially list conditions, if any, leading to immediate | | or as a cons | equence of |): | | | | | | | | |
| . 1 | | Examine | cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death). Las | Dua to / | or as a cons | equence of |): | | | | | | | \dagger | |
| V | executed an and al - transit | Ĕ | | d | | | | | | | | | | ┼─ | |
| |), be exe sician a urial - | dical | UNPENDED | | NDED | | | | | | | 234 [| Date of deliver | <u></u> | |
| | yrds, P.O. Box 68760, w requires that the death certificate be executed is been signed by the attending physician and should be detached for use as the burial - transif | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in | | If yes, outcome Live birth | me of pregr | | etal death | 3 | Ectopic preg | nancy | | | Day | Year |
| | ox 61 ith cert ittendir or use 8 | sicia | past 12 months? 1 Yes 2 ✓ No 9 | Jnknown 4 | Pregnant a | t time of de | ath 5 | Other (Spe | cify) | | | | | | |
| | , BC the dea y the a shed fo | Phys | Part II. Other significant con | 9_ | Unknown outing to deal | th but not re | esulting in the | underlying | cause : | given in Part I. | | | e contribute to | | |
| | P.O. | ۵ | | | | | | | | | _ 1 1 | 'es 2 🗸 | No 3 Pro | | |
| | rds, require been si | Completed | | | | | | | | | | opsy | prior to | completio | ndings available on of cause of |
| | Recol The law cate has page 2 st | | | _ | | | | | | | pei 1 ✓ Ye | formed? | death? | | 2 No |
| | tal Recol | ြပ် | 25. Was case referred to med | | | | | | 26.Plac | e of Death (Che | ck only one) | | | | |
| | n of Vital ling Physician: After this certif funeral director, | 1 B | examiner? 1 ✓ Yes 2 No | Hospital | i Inpati | ient 2 | ER/Outpatie | | DOA | Other ₄ Nur ury at Work? | sing Home 5 | | ce 6 Oth | er: Scene | |
| | n of Viring Physical After this funeral dir | | | ending 28 | a. Date of Inj OUND: OUND: | jury Year) | 28b. Time of FOUND: | or injury | | Yes 2 V No | Subject w | | | | |
| | Sior Attend r death ector: by the | Cati | 2 Accident | vestigation 2 | Sep 4, 2008 Se. Place of I | Injury - At h | 0843 hrs ome, farm, st | reet, factor | y, office | building, etc. | | | d Number or f | Rural Rout | te Number, City |
| | Division of Vital Records, tal or Attending Physician: The law requir as after death. In Director: After this certificate has been stell in by the funeral director, page 2 should it led in by the funeral director, page 2 should it | 1 ≒ | 3 Suicide 6 C | ould not be | Specify) Si | | | | | | 8917 Seve | n, State) n Locks Ro | oad , Bethes | da, MD | |
| | Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis or the Funeral Director: After this certificate has been signed by the attending physis. | | | g Physician: To | the best of r | my knowled | lge, death oc | curred at th | e time, o | date and place, a on, death occurre | and due to the c | ause(s) and | manner as st | ated. the cause | e(S) |
| | Fo the Hos within 24 h To the Fur | Medical | one) 2 ✓ Medical | and_n | e basis of ex nanner stated | amination a | and/or investi | | | nse number | eu at the time, ut | | ate signed (A | | |
| | | 2 | 29b. Signature and title of ce | Al of | ^ | | | | | .M.E. | | | ember 5, 2 | | |
| | <i>a</i> () | | Name and address of per | MALL I | M/J | death (Iten | n 23a) | | | | | | | | |
| | KU | | Pamela E. Sputhal | | istant Me | | | 111 Pen | n Stre | et, Baltimore | , MD 21201 | | | | |
| | | Stat | 31. Date filed (Month, Day, Ye | | Rea | rar's Signat | ture | Park! | | | | | | | |
| | Regi | stra | r eral | 9 2008 | All re | 1400 1 | AT AS | A STATE OF THE STA | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** P 9603 Ronimo ATEMBER MOHIO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AMBROS Birthplace (State or Foreign Country) If Under 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days **™** M 2□ F Hours CLY28 LTAL **Director** 418246 880 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exercine must be notified at 1 ☐ Yes 2 No Director BALTIMOR C)ASSIAN 1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code HEELE Funeral 3406 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc Myes 2 No If Yes, Give Year or Dates: Koka A 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that any lajury or other traumatic event, I've once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ IARDI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINS 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur uneral orvi o Licen 22. Name and Address of Facility 1486 23a. Part1. Enter the disease, or combile a ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Divinto (unas a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. ed by the a 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ∏Yes 2 ∏ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) H0057173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LACRIPHIA ROFO RAIN 82. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | State of Maryland / Department State | | | 0000 00770 |
|----------------|---|-------------------|--|---|--|--|
| | | | 1. Decedent's Name (First, Middle, Last) | rtificate of Death | 2. Date of Deat | eg. No. 2008 28 19 |
| | Physici /Medic | | Eddie W. Jones | | Month | 31,2008 5:58 A M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Dea | | 4c. County of Death |
| ng di | | | Southern Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Clinton If Under 1 Year If Under 24 Hr | 8. Date of Birth | Prince George 9. Birthplace (State or Foreign |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. | Months Days Hours Mir | | Year) Country) 1940 Richmond, VA |
| | put w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo | cation | | 10d. Inside City Limits |
| | Maryla f sho | for | Maryland Prince George Temple Hill | | | Yes 2 No |
| | or 28a | Directo | 10e. Street and Number | 10f. Zip Code | | 0g. Citizen of What Country? |
| | s 23a | ral | 3420 Rickey Avenue Apt 329 | 20748 | | nited States |
| 20 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to notified at | Funeral | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No | Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 21215-0036 | ours a | d by | 3 ☐ Widowed 4XXDivorced If Yes, Give Year or Dates: | 1 ∐Yes 2 Mo Specify: | | Specify: Black |
| | n 72 h "natu edical | Completed | (Specify only highest grade completed) (Give | dent's Usual Occupation kind of work done during most of wo DO NOT use retired) | orking i | 16b. Kind of Business/Industry U.S. Postal Service |
| 212 | d withingiene. | Juo; | Elementary/Secondary (0-12) College (1-4or 5+) | Carrier | | u.s. rostal service |
| g | be filed tal Hyg d othe event, | Be | 17. Father's Name (First, Middle, Last) | | me (First, Middle, M | Maiden Surname) |
| Maryland | d Men marke natic | 은 | Ed Robinson | Dosha | | |
| <u>8</u> | nd 2 sh alth an 27 is r r traur | | | ng Address (Street and Number or F Tellico Place, | | |
| Baltimore, | es 1 av of Hea fitem rothe | | 20a. Method of Disposition 20b. Place of Disposition cemetery, cre- | sition (Name of matory or other place) | Date 8 | 20c. Location - City or Town, State |
| Ĕ | Page tment tant: It | | 4 Donation 5 Other (Specify) Resurrect | ion Cemetery 20 | 08 | Clinton, Maryland |
| Ball | permit. Pages 1 Department of I Important: If ite any Injury or of | 1 | | 2. Name and Address of Facility $ m R_{0} $ | | Mason Funeral Home Inc |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not en | | | est. Approximate |
| | Physician | 8 5 | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Pancy to ben) | <u>. </u> | | Interval Between Onset and Death |
| | /Medical Examiner | | Due to (or as a contequence of): | | .6 | |
| | amiiiioi | -e | Sequentially list conditions, if any, leading to incrediate | ma - non som | ll cell | |
| | cuted nd ransit | Examine | If any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | |
| Ď, | cate be executed physician and the burial-transit | I Ex | resulting in death) Last Due to (or as a consequence of): | | | |
| | ficate be executed i physician and s the burial-transit | dical | d | | | |
| ROX | death certiff e attending d for use as | n/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | 7 | | 23d. Date of delivery |
| | | Physician/Me | in the past 12 months? 1 Yes 2 No 1 Yes 2 No | ☐ Ectopic pregnancy ☐ Other (specify) | | Month Day Year |
| J. | requires that the peen signed by th hould be detache | | 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u | nderlying cause given in Part I | 23e Did tol | bacco use contribute to the cause of death? |
| Vital Records, | uires t n signe ld be c | d by | ESRD | ndosynig dado gwon ii'r arci. | | es 2 No 3 Probably 4 hknown |
| ဂ္ဂ | law req las beel 2 shou | plete | | | 24a. Was a | |
| ř | The cate h | Completed | | | autops perforr 1 □ Yes | med? prior to completion of cause of death? 1 \[\text{Yes} \] 2 \[\text{No} \] |
| <u> </u> | Physician: r this certific ral director, | Be | 25. Was case referred to medical examiner? Hospital: Hospital: | Othor: | eath (Check only on | ne) |
| ō | a Physer this eral dii | Certification: To | 27. Manney of Death 28a. Date of Injury 28b. Time of | f 28c. Injury at | | ence 6 Other (Specify) ow injury occurred |
| DIVISION OF | Attending r death. ector: After by the fune | atio | 2 Accident investigation | Work? M 1 □Yes 2 □ No | | |
| <u> </u> | or Atter fter de lirecto n by ti | rtific | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify) | reet, factory, office | 28f. Location (Si City or Town | treet and Number or Rural Route Number, n, State) |
| ם | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | | 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deal | h occurred at the time, date and pla | ce and due to the o | cause(s) and manner as stated |
| | n 24 h n 24 h ne Fun pletely | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. | estigation, in my opinion, death oc | curred at the time, d | date and place, and due to the cause(s) |
| | Vithi To the | Š | 29b. Signature and title of certifier | 29c. License number | | 29d. Date signed (Month, Day, Year) |
| | | | V. Kuman MD | 063183 | | 09/01/08 |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, VIJAY SIHRI KANNAN 7503 | Print) SURRATTS ROPE | LLIN' | 09/01/08 NO-20735 |
| | Sta | | 31. Date filed (Month, Day, Year) 32. Segistrar's Signature | Early 1 | , , , , , , | - |
| | Registr | ar | SEP 0 9 2008 August A. | | | |

DHMH 17 Rev 1/2001

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| 6 | 0 | I | U | ţ |

| | | | For State Registrar | otato ot marylan | Cei | rtificate of | | omarriy | Reg. No. | 30 20100 |
|----------------------------|--|----------------|--|---|----------------------------------|--|--|---|-------------------------------|---|
| 9 | Physici | an | 1. Decedent's Name (First, Middle, La | | | | | 2. Date of De Month | Day | Year 7:10 P M |
| | /Medic | al | ORIS JOHN 4a. Facility Name (If not institution, giv | SON, JR | | 4b. City, Town, or | r Location of Deat | 09 | 4c. County of | .000 |
| | Examir | er | JOHNS HOPKINS | , | | | MORE, M | | N/A | Death |
| | Funeral Director | | | 6ex 7. Age (In yrs. | | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | (Month, Da | rth | Birthplace (State or Foreign Country) LA |
| | land 5w | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town or Lo | cation | | | | 10d. Inside City Limits |
| | a-f she | ctor | MD | N/A Ba | altimo | ore | | | | 1 ☐ Yes 2 ☐ No |
| | th with the 23a or 28 ist be not | al Director | 10e. Street and Number 5917 Radecke A | venue | | 10f. Zip Code | 21206 | | 10g. Citizen of W | hat Country? |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Married | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No | lispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | 14. Race Black Specify: | - American Indian, s, White, etc. Black |
| 200 | 72 hou natura lical E | ted | 15. Decedent's Ed (Specify only highest gra | | 16a. Dece | dent's Usual Occup | ation | rkina | 16b. Kind of Bus | siness/Industry |
| 21215-0036 | vithin 7 | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | life. I | DO NOT use retired | d) | ткту | Living | Classroom |
| d 2 | filed v Hygie other t | | 12th grade 17. Father's Name (First, Middle, Last, | l year | Sup | ervisor | | me (First, Middle | , Maiden Surname | e) |
| <u>lan</u> | Aentaf Aentaf rked c | To Be | Oris Johnson, | Sr | | | Yvonne | | inson | , |
| Maryland | 2 short and h | | 19a. Informant's Name/Relationship (| | 19b. Mailir | ng Address (Street | and Number or R | ural Route Numb | per, City or Town, S | State, Zip Code) |
| | 1 and 4ealth em 27 ther tr | | Robin T. Johnso | | 5917 | Radeck | e Aveni | e Balt | o,MD 21 | 206 |
| Baltimore, | : Pages tment of t tant: If Ite | | 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif | Removal from State Church | hng M | natory or other place. Ion Bapt emorial | | /08 -2008 | Sparta, | City or Town, State Virginia Letown, MD |
| Ba | Depar Impor any in | | 21. Signature of Funeral Service Licer | ware | 22 | 2. Name and Addre | ss of Facility North | | East F/ ue Balt | |
| Ę, | | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only | plications that caused the deat one cause on each line. | th. Do not ent | er the mode of dyir | ng, such as cardia | c or respiratory a | arrest, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC | | DOELLUI | LAR C | ARCINO | AM | 1 YEAR |
| 0 | Examiner | | | Due to (or as a conseq | luence or): | | | | | |
| | To # | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is the cause) | Due to (or as a conseq | justice of): | | | | | |
| A | and I-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a conseq | mence of | | - | | | |
| 68760, | certificate be executed rding physician and use as the burial-transit | SalE | | . d | jucilico oly. | | | | | |
| | rtificate ng phy as the | Medical | | ty CI | | | | | | |
| .O. Box | <u>8</u> <u>q</u> 8 | Physician/ | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregn: 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c | aldeath 3□ | Ectopic pregnancy Other (specify) | / | | 23d. Date Mon | e of delivery hth Day Year |
| Δ. | s that the post of | | Part II. Other significant conditions of | contributing to death but not res | ulting in the u | nderlying cause giv | en in Part I. | 23e. Did | tobacco use contri | bute to the cause of death? |
| rds | equires en sign ould be | ed by | | | | | | 1 🗆 | Yes 2 No | 3 Probably 4 X Unknown |
| Division or Vital Records, | 2 3 a | Completed | | | | | | 24a. Was auto perfe 1 Yes | opsy property ormed? de | Vere autopsy findings available rior to completion of cause of eath? □Yes 2□No |
| /ita | clan: ertifica ector, p | Be C | 25. Was case referred to medical examiner? | | | | | ath (Check only | | |
| 0 | Physi r this c ral dire | 2 | 1 ☐ Yes 2 📉 No 27. Manner of Death | Hospital: 1 ☐ Inpatient 2 28a. Date of Injury | ER/Outpatier 28b. Time o | | 4 🗀 Nursing i | | idence 6 Othe | |
| sion | Attending Physician: r death. ector: After this certifice by the funeral director, p | Certification: | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | (Month, Day Year) | Injury | M 1□ | yat k? Yes 2 □ No | | how injury occurre | |
| / Divi | Hospital or At 24 hours after o Funeral Direc tely filled in by | | 4 ☐ Homicide determined | building, etc. (Special | fy) | | | City or To | wn, State) | er or Rural Route Number, |
|)) | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | ledical | one) 2 Medical Exam | nysician: To the best of my knominer: On the basis of examination and manner stated. | owledge, deat ation and/or in | vestigation, in my o | opinion, death occ | e, and due to the curred at the time | , date and place, a | and due to the cause(s) |
| 1 | To Voir | Σ | 29b. Signature and title of certifier | lun MD | | 29c. Licens | | 26 | 29d. Date signed | (Month, Day, Year) |
| , | 1. | | 30. Name and address of person who | | n 23a) (Tvne | | \$6763 | | -11410 | 70 |
| | K | | JESSKA COLBURN, | MD JHBMC " | 4940 F | ASTERN | ANE. 1 | BALTIMO | RE, MD | 21224 |
| | Sta Registr | | 31. Date filed (Month, Day, 3ear) | 8 /32. Registrar's Status | ature | EL | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 2008 11:15PM JOHN JONES. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3482 Dolfield If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1**₽**M 2□F 219-44-8242 6a Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Dyes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be Dolfield 21215 14. Race -Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc 1 Des 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Electrician permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If Item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Jones Matti e Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 waterway Ct Towson MD 21286
De of Disposition (Name of Date 20c. Location - City or Town, State Connie Stewart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9.9.2008 Baltimore, Mi Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugnon C. Greene Funeral Service Jau Baltimore, MD 4905 York neemo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC SQUAMOUS CELL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine and Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 (A) Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. Records, Division or Vital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this filled in by the

Maryland 21215-0036

Baltimore,

Medical

29a. Certifier

(Check only one)

State Registrar 29b. Signature and title of certifier MD 141

29c. License number D 0066346.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 09/04/05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 692

1650 ORIGANS STREET, BALTIMORE, MIL

CRB I .S. MARUR 31. Date filed (Month, Day, Year)

0 9

SEP

32. Registrar's Signature

and manner stated.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: he law requires that the death certificate be executed and house deep death. Division of Vital Records, P.O. Box 68760,

| | • | pe or Print in Bi | | | | - | _ | bie. | | |
|-----------|--|--|-------------------------------|---|--|--|--|-------------------------------|-----------------------|--|
| | _ State | State of Maryland | | rtificate of | | | 20 | 08 | 28782 | |
| | Registrar 1. Decedent's Name (First, Middle, Last) | | | tinouto or | Douth | 2. Date of Death | J. NO. | | 3. Time of Death | |
| an cai | Wil | lda Naomi Joh | nson | | | Month Septembe | Day r 4. 20 | Year 008 | 5:10 P. M | |
| ai er | 4a. Facility Name (If not institution, give stre | eet and number) | | 4b. City, Town, o | or Location of Death | • | 4c. County | | 7.10 1 . | |
| | 2011 Halethorpe A | | | 1 | ltimore | | Ba | ltimor | | |
| | 5. Social Security Number 6. Sex | 7. Age (In yrs. la: | s <i>t birthd</i> ay) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | | | ice (State or Foreign | |
| | 217 26 9012 1 M | 70 | 110. | | | 02/18/1 | 930 | Mar | ryland | |
| | 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 100 | d. Inside City Limits | |
| 5 | Maryland Baltimor | e Ba | altimo | ore | | | | | 1 ☐ Yes 2 ♣ No | |
| Ulrector | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of V | | y? | |
| runeral | 2011 Halethorpe A | | | | 1227 | | U.S. | | | |
| 5 | TT TO THE TEXT OF | Was Decedent Ever in U.S. Armed Forces? | 13. | Was Decedent of I If Yes, specify Cub | Hispanic Origin? (S ean, Mexican, Puert | pecify Yes or No- o Rican, etc.) | | e - Americai k, White, etc | | |
| ý | 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ∐Yes 2 X No If Yes, Give Year or Dates: | | 1∐Yes 2XINo | Specify: | | Specify | . Whi | te | |
| | 15. Decedent's Educati | ion | 16a. Dece | dent's Usual Occu | pation | . 10 | l 3b. Kind of Bu | | | |
| Completed | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4or 5+) | | | during most of wor ed) | king | | _ | | |
| | 8th | | Ноп | nemaker | T | | Own H | | | |
| 3 | 17. Father's Name (First, Middle, Last) | orge J. Hogar | , | | | ne <i>(First, Middle, Ma</i> 11ene Frar | | ie) | | |
| 2 | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (<i>Type</i> . Martin Johnson / H | · 1 | | | t and Number or Ru rpe Avenu | ıral Route Number, Balti | | | and 21227 | |
| | 20a. Method of Disposition | | | osition (Name of | pe Avenu | | Oc. Location - | | | |
| | 1 ☐ Burial 2 🗷 Cremation 3 ☐ Rem | noval from State cei | netery, cřei | natory or other pla | i i | | | - | | |
| | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | Bayı | | Crematory 2. Name and Addre | one of Facility | | | | laryland | |
| | Dan DM2 | - | | | G | once Funer | | | | |
| - 1 | 23. art 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. Libronly one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 2122 Approximate Interval Between Organization of the programment of the program | | | | | | | | | |
| | Immediate Cause (Final | | | | | | | | | |
| | disease or condition resulting in death) | Due to (or as a conseque | ence of): | VONICON | s wor care | une D | v) cu/ | | | |
| | Conventially list conditions | V | | | | | | | | |
| LAGIIIII | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque | ence ory: | | | | | | | |
| | Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | resulting in death) Last | Due to (or as a conseque | ence of): | | | | | | | |
| | d | | | | · | | | | | |
| | IF FEMALE: 23c | . If yes, outcome of pregnan | CV | | | | 004 5 | | | |
| | in the past 12 months? | 1 ☐ Live birth 2 ☐ Fetal of | death 3 | ☐ Ectopic pregnan☐ Other (specify) _ | су | | 1 | te of deliver onth | y D ay Year | |
| | 1 □ Yes 2 ☑ No 9 □ Unknown | 9 Unknown | uii | _ Other (specify) | | | | | | |
| . | Part II. Other significant conditions contril | buting to death but not result | ing in the u | nderlying cause gi | ven in Part I. | 23e. Did toba | icco use cont | ribute to the | cause of death? | |
| an Dy | De menta | | | | | 12 Yes | 2 □ No | 3 ☐ Proba | bly 4 🗌 Unknown | |
| | Hyportus | unî | | | | 24a. Was an | 24b. 1 | Were autops | sy findings available | |
| completed | | | | | | autopsy | topsy prior to completion of cause of death? | | | |
| , | 25. Was case referred to medical | | | | 26. Place of Dea | 1 ☐ Yes 2. ath (Check only one | | 1 □ Yes 2 | 2 ☑No | |
|) | examiner? 1 Yes 2 No Hos | pital: 1 ☐ Inpatient 2 ☐ E | R/Outpatie | nt 3 DOA Ot | | lome 5 Resider | | er (Specify) |) | |
| | | 28a. Date of Injury (Month, Day, Year) | 28b. Time o | f 28c. Inju | ırv at | 28d. Describe hov | | | | |
| | 2 ☐ Accident investigation | (| ,, | |]Yes 2□No | | | | | |
| | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At hon building, etc. (Specify) | | eet, factory, office | - | 28f. Location (Stre | eet and Numb State) | er or Rural | Route Number, | |
| 1 | | | | ··· | | | | | | |
| | 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Checkoniv 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | | | | |
| | one) 29b. Signature/and title-of ce/tifier | and manner stated. | | | | | | | | |
| | A SIVU | MA | | 29c. License number 29d. [D SO470 (Type, Print) Highway Pasadeur MD | | | | d (Mpnth, D. | 08 | |
| | 20. Name and address of | plotted source of de the // | 00a) /T | Drint | 7 500 | , - | | 2/100 | - | |
| | 30. Name and address of person who comp SRIDHAR. ATWM, | S109 Ritcle | | igh way | Pasado | eur M | 211 | 21 - | | |
| , | 31. Date filed (Month, Day, Year) | 3. Registrar's Signatu | | 1. | | | <u>~ / / / </u> | | | |
| ır | SEP 0.9 2008 | Bloom & | dos | de | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 7, 2008 **Physician** 5:25 AM Mark W. Kissel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4611 Ridgeway Avenue Baltimore Baltimore 8. Date of Birth Month, Day, May 24, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2□ F 49 220-76-6441 Colorado Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercitme reset be rutified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4611 Ridgeway Avenue 21206 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a and Injury or other treumetic event, the Mydical Experiment unations. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Investigator Private Investigation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick John Kissel Alice M. Magruder ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Kissel 4611 Ridgeway Avenue; Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9/10/08 Towson, MD 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 M 23a. Part 1. Enter the disease, or complications that caused the distance ath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SOMMY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐ Yes 2XNo Hospital Other: 4 \(\sum \) Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation filled in by the fi 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier X 27356

State Registrar Drive, BALTIMORE, MDZIZ3"

30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ATer

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 1, 2008 Physician 12:00 PM Leah Grace Kelly /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Charlestown Retirement Center Catonsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 90 215-18-5342 Director May 11, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. Catonsville Director MD Baltimore 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code **2122**8 10g. Citizen of What Country? 707 Maiden Choice Lane Apt. 8G12 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>م</u> White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Military Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Kelly Mary Ann Fox ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Kelly - Nephew 5524 Charlcote Rd. Bethesda MD 20817 Method of Disposition 20c. Location - City or Town, State west Arundel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Crematory 9-4-2008 Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Euneral Service Licen 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con quence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions cogtributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed: 21-No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) all

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 0 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Mary Lou Kindle 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 424 Bigley Ave Baltimore Lansdowne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/4/1947 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Days 1 □ M 2 🖺 F Director 215-52-4045 60 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show If is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar mass be notified at MD Baltimore Lansdowne Director 1 □Yes 2 N No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21227 United States 424 Biglev Ave filed within 72 hours after death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, It appears own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Doering , Sr. Grace Hoffman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Kindle, Sr./husband 424 Bigley Ave. Lansdowne, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, LLC 9/6/08 Glen Burnie, Maryland ^{22. Name and Address of Facility} Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne, MD 21227 21. Signature of Funera rvice Lic nsee Down 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Metasta 41 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760; attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Ye ar P.0. 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗆 No 1 □ Yes 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day, SEP 0 9

TOV

and manner stated.

MD

2

^{Year)} 2008

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Mutcal Event in the motified at once. Baltimore, Maryland 21215-0036

1 - For State Regis 1. Deceder

Be Completed by Funeral Director

၉

Physician /Medical

Examiner

Funeral

Physician /Medical Examiner

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

0 State

DHMH 17 Rev 1/2001

| Decedent's Name (First, Middle, Las | | | d / Department of Health and M Certificate of Death | | | Reg. No. 2008 2878 | |
|---|---|---|--|---|--|----------------------------|---|
| Amormoth | Registrar 1. Decedent's Name (First, Middle, Last) | | | | | | 3. Time of Death |
| Auarnath | Khetarpal | | | | _ | 8, 2008 | 2:23 A M |
| . Facility Name (If not institution, give | | | 4b. City, Town, o | r Location of Death | - | c. County of Dea | |
| 3022 Alpenhorn Wa | ay | | Silv | er Spring | | Montgo | mery |
| Social Security Number 6. Se | 7. Ag | e (In yrs. last birthday |) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Yea | 9. Bir Co | thplace (State or Foreign |
| 591-03-5247 | AJ WI Z | 80 Yrs. | | | | 1928 | India_ |
| sual Residence of Decedent a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| Maryland Montgomery | | | Silver Spring | | | | 1¥E Yes 2 □ No |
| De. Street and Number | el y | 211 | 10f. Zip Code | 8 | 10g. C | Citizen of What Co | ountry? |
| 2022 Almonhorn U | 0.17 | | | 0.4 | | India | , |
| 13022 Alpenhorn Way 1. Marital Status 12. Was Decedent Ever in U.S. | | | . 13. Was Decedent of Hispanic Origin? (Specify Yes or No- | | | 14. Race - Ame | erican Indian, |
| Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | | If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | Black, Whit | e, etc. |
| | | | 1 ☐ Yes 2 X No Specify: Specify: | | | Specify: As | sian-Indian |
| 15. Decedent's Education (Specify only highest grade completed) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Bus | | | Kind of Business | /Industry |
| Elementary/Secondary (0-12) | College (1-4or 5 | 'life | DO NOT use retire | d) | | | _ |
| 12 | | | General 1 | T | | General : | Business |
| 7. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | | | | | |
| Ram Dass Khetarpal | | | Bhagwanti | | | | |
| 9a. Informant's Name/Relationship (7 | ype. Print) | 19b. Mail | ling Address (Stree | and Number or Rui | al Route Number, City | or Town, State, | Zip Code) |
| Sudhir K. Khetarp | al/son | | 2 Alpenho | | | | land 20904 |
| Da. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | ematory or other pla | atory 9/9 | İ | Location - City or denton, | Maryland |
| 1. Signature of Funeral Service Licen | Aomer | 4 | 22. Name and Addr Donaldson 1411 Anna | ess of Facility Funeral polis Roa | Home & Cre d Odenton | matory, , Maryla | P.A. and 21113 |
| 3a. Part 1, Enter the disease, or comp shock, or heart failure. List only or | lications that caused one cause on each li | the death. Do not en | nter the mode of dy | ng, such as cardiac | or respiratory arrest, | | Approximate Interval Between |
| nmediate Cause (Final isease or condition | a Maxil | lary Carci | noma | | | | Onset and Death 18 months |
| esulting in death) | Due to (or as | a consequence of): | | | |) | |
| equentially list conditions, | b | | | | | | |
| any, leading to immediate | Due to (or as | a consequence of): | | | | | |
| dause (Disease or injury that initiated events esulting in death) Last | C. Due to for on | | | | | | |
| James III John J. Last | Due to (or as | a consequence of): | | | | | |
| | d | | · | | <u> </u> | | |
| FEMALE: | 23c. If yes, outcome | of pregnancy | | | | | |
| in the past 12 months? | | ☐ Ectopic pregnancy | | | Date of delivery Month Day Year | | |
| 1 □Yes 2 □ No 9 □ Unknown | 4 ☐ Pregnant a 9 ☐ Unknown | t time of death 5 | Other (specify) | | | | |
| art II. Other significant conditions co | ontributing to death b | ut not resulting in the | underlying cause gi | ven in Part I. | 23e. Did tobacc | use contribute t | o the cause of death? |
| | | 3 | , , , | | 1 ☐ Yes | 2 TV No. 3 TIP | robably 4 🗌 Unknowr |
| | | | | | | | |
| · · · · · · · · · · · · · · · · · · · | | | | | 24a. Was an autopsy performed? 1 □ Yes 21☑1 | prior to death? | utopsy findings available completion of cause of s 2 \Boxed No |
| . Was case referred to medical examiner? | | | | 26. Place of Deat | h (Check only one) | | |
| 1 Yes 2 No | Hospital: 1 Inpatie | ent 2 ☐ ER/Outpatie | ent 3 DOA Ot | ner: 4 🗆 Nursing Ho | ome 🕉 Residence | 6 ☐ Other (Spe | ecify) |
| 7. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work? | | | | | |
| 2 ☐ Accident investigation | | | | Yes 2□No | | | |
| 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State) | | | | | and Number or F | tural Route Number, |

Medical Certification: To Be Completed by Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for

Treham, M.D. 31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D33224

29d. Date signed (Month, Day, Year)

September 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 8:45 September 5,2008 Cora Marie Koeneke /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HArford Bel Air Bel Air Health and Rehabilitation center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔀 F June 12, 104 1904 Director 212-22-3505 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Directo Harford Abingdon Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 708 Scottish Isle Drive 21009 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Cora Williams Robert Lee Meier 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau Charles K. Koeneke / Grandson 708 Scottish Isle Drive, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 9-9-08 Elkridge, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d Physician omen 2 SNO D /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 D onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient မ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be execute physician Division or Vital Records, P.O. Box 68760 **LOPINGRE** attending SASIE certificate Attending Physician: Director; After this filled in by the funeral within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

A. 31. Date filed (Month, Day, Year)

Kohbert

29b. Signature and title of certifie

Duncan MD 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D. M.C

29d. Date signed (Month, Day, Year)

DINIRA BOD AIRMD 21014

Please Type or Print in Black Indelible Ink, Fnsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 28788 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 5 2008 2:10 P M KOSTISHIN MIKHAIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR TOWSON 6. Sew 1 ☐ M 2 ☐ F 9. Birthplace Country) 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign UKRAINE Funeral 217-25-9957 86 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any Injury or other traumatic event, the Medical Exartinat must be notified at Director 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Ukraine 2012 JOLLY ROAD 21209 Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 🛣 No WHITE Completed by Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAKERY BAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **LEYBOVCH** UNKNOWN HYAM EDA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INNA KOSTISHIN / DAUGHTER 2012 JOLLY ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 D Burial 2 □ Cremation 3 □ Removal from State BALTIMURE HEBREW 09/07/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the deal-Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final MACKITON Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for an a connequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 No 2 🗆 No 1 ☐ Yes 25. Was case reterred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Magner of Leath 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the river after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number september, 5, 2008

State Registrar

31. Date filed (Month, Day, Year)
rar

SFP 0 9 2008

Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 No.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 28789 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Day **Physician** 930 AM JAMES PAUL KRAUS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
JUNE 18,1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □**X**M 2 □ F Months Days Hours 216-36-0129 69 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County es 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygene.
If item 27 Is marked other than "natural", or items 23a or 28a-f show it nother traumatic event, the Medical Examinar must be realthed as when the Medical Examinar must be realthed as 1 ☐ Yes 2 🙀 No Funeral Director FULLERTON MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 107 LINHIGH AVE 21236 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 □ Yes 2 □ No Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FIREFIGHTER BALTIMORE CITY 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be MARY MURPHY FREDERICK KRAUS P Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FULLERTON, MD 21236 MARCELLA KRAUS-DAUGHTER 107 LINHIGH AVE permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/6/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21, Signature of Funeral Service Licenses BALTIMORE, MD 21206 6415 BELAIR RD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of) arter DISEASE disease or condition resulting in death) /Medical Examiner Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans attending physician and cardiac arrhyThmia resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, yperkalemia IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No sbeen signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Diabetes melliTus 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Anemia certificate has page 2 autopsy 1 ☐Yes 2 ☐No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 5 Pending 1 ☐Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 9-2-2003 H40769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 OLD Emmorton Rd Belain md 21015 DR GREGORY
31. Date filed (Month, Day, Year) 2227 M. Dohmeler 32. Registrar's Signature State Registrar SEP 0 9 2008

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Registrar

State

29b. Signature and title of certifies

DR/ANDO

SEP

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

CONANA

32 Registrar's Signature

29c. License number

NORTHWEST HOSPITAL

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 9 **Physician** 2:00 P M 2008 Willie Ladson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Haven N/H Balto If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 ☐ M 2**汉** F Director 237-38-2728 8-30-1927 N.C. Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 1334 N. Chester Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3√Vidowed 4 ☐ Divorced by Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " any injury or other traumatic event, the Meany injury or other traumatic event, the Means Elementary/Secondary (0-12) College (1-4or 5+) Seton N/H Nursing Assistant llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nezzie Little Alex Rorie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21229 Paula L. Gillis-Daughter 29 Cobber Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Nat 20c. Location - City or Town, State 20a. Method of Disposition 1 \(\overline{\begin{align*} \begin{align*} \begi 9-10-2008 Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Wan 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONT Due to r as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical IF FEMALE: þ

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

been signed by the should be detached has le 2 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate he completely filled in by the funeral director, page Be P Medical Certification:

Division or Vital Records, P.O. Box 68760

| 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month Day Year |
|--|---|---|
| Part II. Other significant condition | no contributing to death but not reculting in the enderlying edges given in activities | Did tobacco use contribute to the cause of death? |
| | | I Yes 2 No 3 Probably 4 ₽Unknown |
| | a | Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |
| 25. Was case referred to medical | 26. Place of Death (Check or | nly one) |
| examiner? 1 ☐ Yes 2 🛺 No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ F | Residence 6 Other (Specify) |
| 27. Manner of Death 1 Natural 5 Pending 2 Accident investign | (Month, Day Year) Injury Work? | ribe how injury occurred |
| 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi | 28e. Place of injury - At nome, famil, street, factory, office | on (Street and Number or Rural Route Number, r Town, State) |
| | g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the ti and manner stated. | |

29c. License number

15503

29d. Date signed (Month, Day, Year)

September 8 2008

State Registrar

29b. Signature and title of certifier

501 Daphinstr

Macem MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28792 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year Lovelace Percy Lee aemograes 6 8008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 XM 2 □ F Months 229-16-6074 83 Vrs 10-24-1924 VA Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ¥☐Yes 2☐No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1612 E. 25th Street 21213 US Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 → Married Specify: Black 1 ☐Yes 2 XNo Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless 7th grade Steel Worker Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry L. Lovelace Missy Crews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherley Lovelace-Wife 1612 E. 25th Street Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Tk 9-13-2008 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 5 Radi 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Monary weeks Due to (or as a consequence of) SIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Physician /Medical Examiner Attending Physician: The law requires that the death certificate be executed

Pg

physician

attending

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signed by

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this certificate

Hospital or n 24 hours a

within 2 To the I

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò 23a

"natural", or items

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, Item Many Injury or other traumatic event, Item Many

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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traumatic event, the Medical Examinar must be notified at

Examiner Physician/Medical as use ō detached 2 page 2 should be Completed ours after death.

eral Director: After this certific filled in by the funeral director, I Be Certification: To

1 □Yes

2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | → Ko 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Date of Injury (Month, Day, Year) Injury

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work? 1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d, Date signed (Month, Dav. Year)

29b. Signature and title of certifier

6 □ Could not be

State Registrar

Medical

McEncenson. thian Memorial Hospital, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George H. Lacock September 5,2008 12:52 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Hours Min Months 189-10-6252 Director 88 APR 11,1920 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5448 Glenthorne Ct 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12/Yes 2 □ No If Yes, Give 1942— Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced 945 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Adjuster Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George H. Lacock Rachel Edwards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Lacock/Daughter 5448 Glenthorne Ct Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/6/08 4 Donation 5 Dother (Specify) Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD C. Todd Dring Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on your cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.

Funeral Director: After thietely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

within 2

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 0 9 29d. Date signed (Month, Day, Year)

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print) MUES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🛭 🧍 🥱 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:45 A M James -awrente sept 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore HOSPiral Agres If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 219-40-7276 Director 600 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me Acal Examiner must be notified at 1 Pres 2 □ No Director Baltimore MD10g. Citizen of What Country? 10e. Street and Number Fairview 21216). S.A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter 1 Yes 2 Ho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Gas aborer 12+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be F. Lawrence Fulton كودو ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health as
Important: If Item 27 is
any Injury or 1662 Shadyside 12 Bultimore MD 21218

e of Disposition (Name of Date 20c. Location - City or Town, State E. Lawrence <u>Ethel</u> altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 9.8.2008 Baltimore, MD Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Oreene Fureral Services 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Bultimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Shock septic Physician 3 days /Medical Due to (or as a consequence of): Examiner extremit lower Right Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Perpheral vasculai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by Srann Memidillin resistant 1 | Yes 2 | No 3 | Probably 4 | Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an preumonia autopsy performed?/ 1 Yes 2 No esophag 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Department 2 ER/Outpatient 3 DOA 1 Tyes Certification: To 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director; A 2 Accident the Funeral Directory filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide to crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P20465 Sept, 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUNES 130 DDW. NEERASA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

LOW JENC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8,18,per FH g883 9/11/08 TT
State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 6 Year **Physician** LAWTON 3:15 AM THELMA MARY 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HOSPITAL HARBUR | FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Apr - 26 | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Feet) | Gountry | Country | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗹 F 212-09-7646 92 1916 Michigan Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show is 23a or 28a-f shov must be notified at 1 Yes 2 □ No Director MD. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Expression mat E. Patapsco Avenue 21225 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Beauty Shop 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Merrit Hook Frank ပ Mary H. Guilfoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 682608 Park City, Utah 80468 R. Dodd Lawton, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial : 9/9/08 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee monecall 4001 Ritchie Hgwy Balto. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FAILURE. RENAL UNKNOWN ACUTE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>á</u> CHRONIC OBSTRUCTIVE AIRWAY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑No ours after death.

eral Director: After this certifical filled in by the funeral director, page 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008 RES OOO Chec.quala SEPTEMBER & 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET, RALTIMORE, MARYLAND 21225 DYIJE IHEAGWARA, 31. Date filed Month Day, Yea 2008 32. Registrar's Signature State Registrar

Physician /Medical Examiner The law requires that the death certificate be executed

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedlen Example of the multiple once.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records.

Division of Vital Hospital or Attending Physician:

attending physician and the detached ģ has certificate Director: After this in by the funeral death. 24 hours after one Funeral Direc

Examine Physician/Medical ğ Completed Be (Certification: To

1 Natural 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

044395

SEPTEMBERS, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES STI SUITE 209 BRITIMORE, MD 21204 DANIEUE DEBERMAN, MO

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a Certifier

32. Registrar's Signature

and manner stated.



within 2 the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5.30 PM Della Moore OL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Forest Haven N/H Catonsvill
If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace Country) **Funeral** Days Hours Min. Months 1 □ M 2√2 F Yrs. 100 Director NC 246-62-2048 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Revideal Examinar must be notified at 1 ☐ Yes 2 XNo Director Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21228 701 Edmondson Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes **X**□ No If Yes, Give Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify: Black \$ 3 ₩Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Farmer Farm na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Romus Moore Mary Jane Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2: ment of Health a 3022 Rosalind Ave, Baltimore, Md 21215 Hattie Keene-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State permit. Page: Department o Important: If i any injury or injury or Moore Family Plot 9/13/08 Williamston, NC 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility March West F/H 4300 Wabash Avenue Balto, MD 21215 torume 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner V Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical as the the attending IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🗆 Ectopic pregnancy for Month Day Year 5 Other (specify) detached 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen Cina Rasc 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760. Ö ۵. Division of Vital Records,

Hospital or Attending Physician: 724 hours after death.
Funeral Director; After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Medical

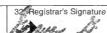
29a, Certifier

State Registrar

DR. A. AHMED 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2008 SEP 09



N. Eulaw

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

621



1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Dav Year **Physician** : 18PM I O SEPTEMBER 4.2008 /Medical Facility Name (If not institution, give street and number, 4b_City. 4c. County of Death Town, or Location of Death Examiner JION MEMORIAL Social Security Number 6. Sex Date of Birth 9. Birthplace (State or Foreign rs. last birthday) **Funeral** Days 1**X**M 2□F Months Hours Min. 214-50-0421 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the model of Event and its periodities at MP Director 1 □ **x**es 2 □ No more 10e. Street and Number 10g. Citizen of What Country? death with Funeral 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ould be fi Pherson should and Men Informant's Name/Relationship (Type Probles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is 1. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Parial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Lie 140180 23a. P/rfi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** PHEUMONIA MOUTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EPHAWCA MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner BACTEREMIA The law requires that the death certificate be executed physician and s the burial-trans MUNTH resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the attending p use as IF FFMA(F 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform Vital F certificate 2 ⊠No 1 ☐ Yes 2 1 NO 1 □ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Impatient this (2 ER/Outpatient 3 DOA Medical Certification: To Division of After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu М 1 □Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSKIAIS MEMORIAR MAP UNION 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

09

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4MES /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Kandallstour Jorthwest Hospital Kaltima If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12 M 2 F Months Days Min. Hours 3 Yrs. Director Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Baltimore 1 es 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funerai 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. iled within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent; if item 27 is any injury or other trat Q000. 6636 Eberle Dr# 201 Baltimore, MD 21215 altimore. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 9-9-08 Baltimore, MD, voughn c. Greene funeral sno eenmount * 4 ☐ Donation 5 ☐ Other (Specify) Y anethy 21. Signature of Funeral Service Licensee Rd. Randallstown, MD21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy tor in the past 12 months? Month 4☐ Pregnant at time of death Day Year ed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 1 Yes 1 ☐ Yes 2 No 2. No Physician: within 24 hours after death.

To the Funaral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

COLO 31. Date filed (Month, Day, Year)

2008

1. Decedent's Name (First, Middle, Last)

Geraldine M. Morris

4a. Facility Name (If not institution, give street and number)

a.m.

SEPTEMBER

Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year, 12/5/1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🛣 F 220-36-6833 68 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiter must be notified at 1 ☐ Yes 3√No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1119 Overbrook Road 21239 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Specify: White 1 ☐ Yes 2 ☑ No Specify: <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry alth and Mental Hygiene.

27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) William G. Brunner Margaret Schmidt ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Robert Morris / Husband 1119 Overbrook Road Baltimore, MD 21239 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 19/8/2008 Hilltop Serv. Corp. Towson, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson, Maryland 21204 1/elil Ruck Towson Funeral Home, Inc. 1050 York Road Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this HOSPICE Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 24 hours after death. 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D Medical 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Reg. No. 2008

2008

4c. County of Death

2. Date of Death

September

28800

AM

9:55

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Mildred Edna Montgomery September 06,2003 5:33 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore County Towson 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | March 06,1927 | Baltimore, MD. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗗 F 216-24-1060 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, for Medical Evansian must be indiffed at 10c. City, Town or Location 10d. Inside City Limits Maryland N/A 1 XYes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 Hickory Ave. 21211-1743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 22∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖼 No Specify. δ White 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Streeter Margaret Streeter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau David L. Montgomery, Jr. (Sori) 4013 Hickory Ave. Baltimore, Maryland 21211-1743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Sept 2008 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cem. Woodlawn,Maryland 4 □ Donation 5 □ Other (Specify) Bengsand Address flacily tives Funeral & Cremation Ctr., P. A. 2325 York Road Timonium, Maryland 21093 21. Signature 23a. Part y Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) */Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any souling to introduce cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a I be detached for 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has trector, page 2 s 24a. Was an 1 ∐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation s after death.
I Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide Hospital 24 hours e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To the I and manner stated 29b. Signature and title of certifier License number 29d. Date signed (Month. Dav. Year)

State

DHMH 17 Rev 1/2001

Registrar

Towsertown

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 28804 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Da September **Physician** 5:30 JOHN JOESPH MCKENNA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 12604 Cedarbrook Lane Laurel 8. Date of Birth (Month, Day, Y NOV . 13, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year, Days Hours Min New York 1-√2 M 2□ F 094-26-6998 78 1929 Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Laurel 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 23a 12604 Cedarbrook Lane 20708 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

13. Was 2 \(\text{No } \) No 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XXMarried altimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: -1959 Specify: Specify: \$ White 3 Widowed 4 Divorced natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government/ and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NASA Engineer / Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be John Michael McKenna Margaret Murphy ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is,
any injury or other trau Mary Lou McKenna spouse 12604 Cedarbrook Lane Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Kurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 9/11/2008 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee / M00770 313 Talbott Avenue Laurel, Maryland 20707 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final Physician Prostate Cancer, Metastatic years disease or condition resulting in death) /Medical Due to (or es a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy for in the past 12 months? Day Year Month 5 ☐ Other (specify) ☐Yes 2☐No P.O. been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 Diabetes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No Coronary Artery DIsease 24a. Was an page 2 s has certificate 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Cutpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred of or Attending Fafter death. After Division 5 Pending investigation 1XXNatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24997 Sept. 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Cherry Lane Luis A. Casas, M.D. Laurel, Maryland 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 09 Registrar

State of Maryland / Department of Health and Mental Hydiana

| | | | For State | State of M | arylan | - | artment of h rtificate of | | | _ | 2000 | 200 | 205 | |
|---------------------|--|-------------------|--|--|------------------------------------|---------------------------------|--|---------------------------------------|---|--------------------------|----------------------------------|----------------------------------|----------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, La | st) | | 001 | incate of | Deam | 2. Date of De | Reg. No. | 2000 | 3. Time of E |) U J | |
| | Physici | an | | | | | | | Month | Day | | | P ^M | |
| - | /Medic | | Mary Ellen Magary 4a. Facility Name (If not institution, giv | | | | Ab Ob Torre | r Location of Dea | Septem | 1 | 4, 2008 County of Death | 12:45 | P | |
| | Examir | ier | 7401 Westlake Te | | | 0 | Bethe | | uı | 40. | | 0.227 | | |
| | | | 5. Social Security Number 6. S | - | | ast birthday) | If Under 1 Year | | S. S Date of Bir | th | Montgom | ery place (State or | Foreign | |
| | Funeral Director | | | M 2 XIF '. ^ § | 86 | Yrs. | Months Days | Hours Min | . (Month, Da | y Year) | Cour | Jersey | | |
| | | | Usual Residence of Decedent | | | | | | Aug. 1 | J, 1 | JZZ New | Jersey | | |
| | land ow | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 1 | 0d. Inside City | y Limits | |
| | Mary f sh | ţo | Maryland Montgom | orv | Bo. | thesda | | | | | | 1 □Yes | 2 X No | |
| | the 28a | rec | 10e. Street and Number | CLY | | chesua | 10f. Zip Code | | | 10a. Citi: | zen of What Cour | ntry? | | |
| | 3a of | | 7401 Westlake Ter | race. Apt | . 210 | | 20817 | | | Unit | ed State | S | | |
| | 72 hours after death with the Maryland natural", or Items 23a or 28a-f show item Evan and out the motified | Funeral Director | 11. Marital Status | 12. Was Decedent | | | Was Decedent of H | lispanic Origin? (| | | 14. Race - Americ | | | |
| " | r Iter | Fur | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ∐Yes 2 📉 | No | | f Yes, specify Cub | an, Mexican, Puèi | to Rican, etc.) | | Black, White, | etc. | | |
| 03 | urs a | b | 3 X Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | | I∐Yes 2 X No | Specify: | | | Specify: Whi | te | | |
| 5-0036 | 2 hor | Completed | 15. Decedent's Ed | lucation | - 1 | 16a. Deced | dent's Usual Occup | pation | | 16b. Kir | nd of Business/Inc | dustry | | |
| 7 | iii | ble | (Specify only highest gra | de completed) College (1-4or t | 5.1 | (Give life. L | kind of work done DO NOT use retire | during most of wo d) | rking | (1 | | | | |
| 2121 | giene ar the giene | E O | 12 | Conege (1-40) | 77, | Secre | tary | | | Edu | cation | | | |
| b | othe /ent, | Be C | 17. Father's Name (First, Middle, Last, | 1 | | | | 18. Mother's Na | me (First, Middle | , Maiden | Surname) | | | |
| <u>a</u> | ld be fenta rked rlc e | To E | Daniel McCarthy | | | | | Julia | Sullivan | | | | | |
| ar. | shound N | | 19a. Informant's Name/Relationship (| Type. Print) | | 19b. Mailir | ig Address (Street | | | | r Town, State, Zip | Code) | | |
| Ž | nd 2 alth a 27 is | | Janice A. McGahey | /Daughter | | 10306 | Fleming | Ave., B | ethesda, | MD : | 20814 | | | |
| Baltimore, Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the model Evan, increment in the donce. | | 20a. Method of Disposition | | 20b. P | lace of Dispo | sition (Name of | 20) | Date | 20c. Lo | cation - City or To | wn, State | | |
| 2 | Page ent c nt: If ry or | | 1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | Mon | tgomer | um, Inc. | Sept | ember 9, | B 0 + 1 | hesda, M | ת | | |
| ₩ | artm ortar Inju | 1 | | Al Donation 5 Other (Specify) Crematorium, Inc. 1 2008 Beth Signature of Funeral Service Licensee M01346 Bethesda-Chevy Chase, Inc. 755 Bethesda, MD 20814 | | | | | | | | | | |
| B | Per July Ber | | AS S | | ase, Inc | 75 | 57 Wisco | nsin A | ve. | | | | | |
| | | | 23a. Part 1. En er the disease, or com | plications that caused | MO1 | | | | | | | Approximate | | |
| | | | shock, or heart failure. List only Immediate Cause (Final | one cause on each li | ne. | | | | • | | | Interval Betw Onset and D | /een | |
| | Physician /Medical | | disease or condition resulting in death) | | | | ovascula: | r Diseas | e | | | | | |
| 7 | Examiner | | | Due to (or as | a consequ | uence ot): | | | | | | | | |
| | | ē | Sequentially list conditions, if any leading to immediate | b. Due to (or as | a consequ | uence of): | | | | | | | | |
| $\sqrt{}$ | nsit | Ē | cause. Enter Underlying Cause (Disease or injury that initiated events | 200 10 (0.00 | a company | 301100 0111 | | | | | | | | |
| | execu n and al-tra | Examiner | that initiated events resulting in death) Last | c Due to (or as | a consequ | uence of): | | | | | | | | |
| 68760, | Physician: The law requires that the death certificate be executed ribins certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit | | | | | | | | | | | | | |
| 387 | rtificate ng phy: as the | Physician/Medical | | . O | | | | | | | | | | |
| × | eath certil attending for use as | Ĭ, | IF FEMALE: | 23c. If yes, outcome | of pregna | ncv | | | | | Od Data of dalis | | | |
| Вох | eath ce attendii for use | ciar | 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2X No | 1 ☐ Live birth 4 ☐ Pregnant a | 2 Fetal | death 3 | Ectopic pregnand Other (specify) | Ey | | - | 23d. Date of delive Month | | ear | |
| Ö | at the de by the tached | ysi | 1 ∐Yes 2. Mo 9 ☐ Unknown | 9 Unknown | it time or a | cati 5_ | Jourer (specify) _ | | | | | | | |
| σ. | that the post of t | | Part II. Other significant conditions of | ontributing to death b | ut not resu | ılting in the ur | nderlying cause giv | en in Part I. | 23e. Did 1 | obacco u | se contribute to the | ne cause of de | eath? | |
| Vital Records, | sign sign d be | Completed by | Hypothyroidism | - | | - | | | 1□ | Yes 2 | Z TNo 3∏ Prob | ably 4 ☐ U | nknown | |
| Ö | w requir been s should | etec | | | | | | * | | | T | | | |
| ě | e law has le 2 s | du | | | | | | | 24a. Was auto | osv | | psy findings a mpletion of ca | | |
| = | : The cate h | S | | | | | | | 1 ☐ Yes | rmed? 2 □ No | death? 1 ☐ Yes | 2□No | | |
| Zi. | slcian: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Haarital | | | la. | | ath (Check only o | ne) | | | | |
| of | Phys this al dir | ျှ | 1∐AYes 2□No | | | ER/Outpatien | | 4 LI Nursing I | | | ☐ Other (Specif | y) | | |
| _ | മ വ വ | on: | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | | 28b. Time of Injury | Wor | | 28d. Describe | how injury | occurred | | | |
| Division | or Attending after death. Director: After in by the fune | Certification: | 2 Accident investigation 3 Suicide 6 Could not be | | | | | Yes 2 □ No | | | | | = | |
| ≅ | frer d irect | ŧ | 4 Homicide determined | 28e. Place of Inj building, et | ury - At ho c. <i>(Specif</i>) | me, farm, stre | eet, factory, office | | 28f. Location (| Street and wn, State) | d Number or Rura | al Route Numb | er, | |
| | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | | VZ. | | | | | | | | | | | |
| | Hosp 4 hor Fune ely fi | ica | (Check only 2 Medical Exar | ysician: To the best niner: On the basis o | of examina | włedge, death tion and/or in | n occurred at the ti vestigation, in my o | me, date and place opinion, death occ | e, and due to the urred at the time. | cause(s) date and | and manner as splace, and due to | stated. the cause(s) | | |
| | the hin 2 the I | Medical | one) | and manner st | ated. | | | | | | | | | |
| | 0 1 wit | - | 29b. Signature and title of certifier | 1/00.50 | | MiD. | 29c. Licens D276 | | | 29d. Date | e signed (Month, | uay, Year) | | |
| | | | Migraher | , viwa- | 7 | | | | | 7/ | 4/08 | | | |
| | 10 | | 30. Name and address of person who | | | | | | | | l | | | |
| | 1 " | | Alpana Goswami, M | | | | Pike, # 1 | 110, Rock | cville, | MD 20 | 0852 | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registr | ar's Signa | ture 7.0 | 120 | | | | | | | |

Physician /Medical

Funeral

Director

28a-f show

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23a

or items

"natural"

than

: 1 and 2 should be filed wi f Health and Mental Hygien tem 27 is marked other th

mit. Pages 1 and 3 partment of Health sortant: If item 27 / Injury or other tr

Department or Important: If any injury or

72 hours after

Maryland 21215-0036

Baltimore,

traumatic event, the Medical Examinar must be notified at

Examiner

and

Examiner burial-tran attending physician for use as the buria Physician/Medical ed by the a Ď page 2 should Completed director, Be n 24 hours after death. e Funeral Director; Aft etely filled in by the fun

Hospital or Attending Physician: The law requires that the death certificate be executed

peen

has

certificate

this

After t

within 24 ho

To the Fune

completely f

P.O. Box 68760,

Division of Vital Records.

Certification: To 27. Manner of Death 29a, Certifier Medical

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown End Stage Alzheimer's Disease Sick Sinus Syndrome 25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No

1 X Natural

2 Accident

3 Suicide

4 Homicide

Pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of)

23c. If yes, outcome of pregnancy

Live birth 2 Fetal death 4 ☐ Pregnant at time of death 5 Other (specify)

3 Ectopic pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Day

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

Approximate Interval Between Onset and Death

Year

1 Week

28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number D24543 29d. Date signed (Month, Day, Year) September 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Hospital:

3305 N. Leisure World Blvd., Silver Spring, Maryland 20906 James A. Rossi, M.D.

31. Date filed (Month, Day, Year) State SEP 0 9 Registrar

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | _ State | Department of Health and M | ental Hygie | ne |
|----------------------------|--|-------------------|--|--|---|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | Certificate of Death | Reg. | No. 2008 2880 7 |
| | Physici | | Douglas Bruce McKay, Sr. | | Month September | Day Year 11:50 P.M |
| and the | /Medio | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | - | 4c. County of Death |
| april . | | | Montgomery Hospice Casey House | Rockville | | Montgomery |
| | Funeral Director | | 5. Social Security Number 100-32-0676 0. Sex 1 ☑ M 2 ☐ F 68 Usual Residence of Decedent | Months Davs Hours Min. | 8. Date of Birth (Month, Day, Ye lug. 26, | 9. Birthplace (State or Foreign Country) New York |
| | yland now | | | wn or Location | | 10d. Inside City Limits |
| | a-fst | ctor | Maryland Montgomery Potoma | ıc | | 1 □Yes 2 🙀 No |
| | iff the | Dire | 10e. Street and Number | 10f. Zip Code | _ | Citizen of What Country? |
| | eath v | Funeral Director | 10816 Kirkwall Terrace 11. Marital Status 12. Was Decedent Ever in U.S. | 20854 | | ited States |
| 21215-0036 | d 2 should be filed within 72 hours after death with the Maryland hand Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mariteal Examir or must be treffined at | by | 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: | Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White |
| 2-0 | 72 hor | eted | 15. Decedent's Education 16 (Specify only highest grade completed) | Sa. Decedent's Usual Occupation (Give kind of work done during most of working | 16b | . Kind of Business/Industry |
| 121 | within jiene. | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | (Give kind of work done during most of workir life. DO NOT use retired) XECUTIVE | | siness Machines |
| d 2 | filed v Hygie other 1 | | 17. Father's Name (First, Middle, Last) | | (First, Middle, Maid | |
| ılan | should be filed within and Mental Hygiene. s marked other than umatic event, Ins Ma | To Be | Donald G. McKay | Dorothy (| Carroll | |
| Maryland | 2 short and I is ma | | | 9b. Mailing Address (Street and Number or Rura | | |
| e, R | 5 m O L | | | 0816 Kirkwall Terrace, | | • |
| Baltimore, | of of | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State | tery, crematory`or other place) | | Location - City or Town, State |
| Altin | permit. Pag Department Important: I any injury o | | 4 □ Donation 5 □ Other (Specify) Montgon 21. Signature of Funeral / e. ce Assessment | nery Crematorium, Inc. Sept. 8 | | |
| Ä | permi Depar Impo any ir | | M00896 | 300 W. Montgomery Av | re., Rock | ville, MD 20850-2805 |
| | Di | | 23a. Part 1. Enfer the disease, or complications that caused the death. Do shock, or ceart ailure. List only one cause on each line. | o not enter the mode of dying, such as cardiac o | r respiratory arrest, | Approximate Interval Between Onset and Death |
| 4 | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence) | e of). | | |
| | Examiner | | | 5 01). | | |
| 7 | pe tis | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury) | e of): | | |
| / | and al-trans | Examine | Cause (Disease of injury that initiated events resulting in death) Last C | e of): | | |
| 68760, | ificate be executed g physician and as the burial-transit | edical E | d | ,- | | |
| | | /ledi | IS SEMANG. | | | |
| Box | death certifi e attending d for use as | ian/I | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea | | | 23d. Date of delivery Month Day Year |
| P.O. | 0 0 0 | Physician/M | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown | 5 Other (specify) | | Wildliff Day Fear |
| | s that I | by Ph | Part II. Other significant conditions contributing to death but not resulting | in the underlying cause given in Part I. | 23e. Did tobacc | co use contribute to the cause of death? |
| ords | en sig | | | | 1 ☐ Yes | 2 ☐ No 3 ☐ Probably 4 🖾 Unknown |
| ecc | The law requires that the diate has been signed by the page 2 should be detached | Completed | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| a H | r: The icate h | | | | performed 1 □Yes 2 🖾 | ? death? |
| Vit | siciar certif | Be | 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inputient 2 □ FR/6 | 26. Place of Death | | Inpatient Hospice |
| ı of | g Phy erthis eral d | n: T | 27. Manner of Death 28a. Date of Injury 28b. | Time of 28c. Injury at 2 | ne 5 Residence | o Dottler (Specily) |
| ior | endin sath. or: Aff he fun | atio | 1 💆 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation | Injury Work? M 1 □Yes 2 □No | | |
| Division of Vital Records, | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page | Certification: To | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify) | farm, street, factory, office | 8f. Location (Street City or Town, St | t and Number or Rural Route Number, late) |
| | spital ours a neral t | | 29a. Certifier 1 Certifying Physician: To the best of my knowled | Te death occurred at the time date and place | and due to the caus | a(c) and manner as stated |
| | ne Hoo n 24 h ne Fur pletely | Medical | (Check only 2 Medical Examiner: On the basis of examination a and manner stated. | and/or investigation, in my opinion, death occurre | ed at the time, date | and place, and due to the cause(s) |
| | Voithi Comp | ğ | 29b. Signature and title of certifier | 29c. License number | | Date signed (Month, Day, Year) |
| | 20 | | y 9. Round of | 200 63 748 | | September 7, 2008 |
| 1 | 20 | | 30. Name and address of person who completed cause of death (Item 23a Jocelyne Toukep Kouatchou, M.D., | | Pooles: | ille MD 20855 |
| | Stat | e | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | i., KOCKV | 111e, IID 20033 |
| | Registra | | SEP 0 9 2008 | Barele | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:56 AMM Neighoff Levina Se ptember 2008 Thelma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Northwest Hospita | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 12, 1909 Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) **Funeral** 1□ M**XX** F Months Yrs 99 215-24-9934 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Exendiner must be notified at 1 ☐ Yes 🛂 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 116 Delight Rd. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 龙函 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes X2X No Specify: Specify: White þ XX Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rosewood State Elementary/Secondary (0-12) College (1-4or 5+) Hospital Food Service Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othany Injury or other traumatic event William Scheufele (unknown) Johanna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Neighoff / Son 4020 Osborne Rd. Reisterstown, MD 21136 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition X⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/10/08 Sykesviile, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature Weral Service License where 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Rendl Failure / Dehydration 6 months disease or condition resulting in deeth) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a sor sequence of): Examine be executed burial-transit 30 Years Artery Coronary and Due to (or as a consequence of): attending physician for use as the buria 68760 Physician/Medical Fi brillation 20 years Atrial Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Not Applicably 5 Other (specify) P.0. Not Applicable signed to the detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Alz heime's Dementia, Throm bocytopenia page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HTW autopsy performe 25. Was case referred to medical examiner? certificate Bradycardia Synd rome 1 ☐ Yes of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the Wasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi Medical (Check only one)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month SE) 2008

29b. Signature and title of certifier

Rupsh Vakil, Medical 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doctor

29c. License number

DO067620

29d. Date signed (Month, Day, Year)

Northwest Hospital Center

Randally Town, Maryland

september 7, 2008

21133-5185

Medical Doctor

08-06747 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28809 Robin C. Naresky 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 3, 2008 1408 hrs Medical Examiner ROBIN C. NARESKY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Franklin Square Hospital Center Rosedale 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Director M 2X F Yrs 18 1958 MD 49 SEPT. 216-80-2884 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No or 28a-f show BALTIMORE MIDDLE RIVER with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8 D ALDER DR. 21220 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes Specify: WHITE Yes 2 X No specify: Yes. Give Year Divorced Widowed 4 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) nore, MD 21215-0036
sages 1 and 2 should be filed within 72 ho
and of Health and Mental Hygiene
11: If item 27 is marked other than "na
other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE CITY FIRE DEPARTMENT PARAMEDIC 12TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORMA KLINE HENRY WEBER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) 8 D ALDER DR., MIDDLE RIVER, MDRICHARD NARESKY/HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, Pages 1 tment of 7 crematory or other place) Burial 2 X Cremation 3 Removal from State 09/09/2008 HANOVER, MD ARDENT Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** 23a Part I. Enter the disease or complications failure. List only one cause on each line. Between Onset and /Medical Death Probable drug intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner couse: Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f, perME, g885 11/21/08 TT X UNPENDED AMENDED ned by the attending physician detached for use as the burial Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 V No 3 Probably 4 Unknown Completed ficate has been s, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? 1 🗸 Yes 2 ✓ Yes 2 Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 ✓ Inpatient 2 Other; DOA Nursing Home 5 Residence 6 Other: ER/Outpatient 3 1 V Yes After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natura 1 Yes 2 X No Pending Funeral Director: tely filled in by the 8/31/08 unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 8 ALder Ct. Baltimore apartment determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

29b. Sid

Laron Locke MD.

D O

OCME

'g"2008

31. Date filed (Month, L

e and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

\$2 Registrar's Signature

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year enneth Owens 12:25 AM Sept 0,0 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
Under 1 Year | If Under 24 Hrs. Memorial nion 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country). Months Days Hours 1**□**₩ 2□F 215-46-9258 42 Yrs -1-1946 Mi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 HYes 2 No W Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 2614 21218 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4yrs U.S Post ostal MOCKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wiley owens, Sr solve. Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Baltimore, MI) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9.12.2008 Baltimore, MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4405 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lune Cance year Due to (or as a consequence of): Brain Mass 1 year Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of deliver Year f death? Unknown gs available of cause of umber

Examiner certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

Director

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Completed

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ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once.

Physician

/Medical

Examiner

with the Maryland

and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

| cate be executed obysician and the burial-transit | dical Examir | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | Due to (or as a consequence of): | | | | | | | | | |
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| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown | al death 3 Ectopic | | | 23d. Date of delivery Month Day Y | | | | | | |
| aw requires that s been signed t s should be deta | Completed by PI | Part II. Other significant conditions of | contributing to death but not res | sulting in the underlying | cause given in Part I. | | 2 No 3 Probably 4 U | | | | | | |
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| sicia certi recto | Be | 25. Was case referred to medical examiner? | Hospital: | | Othor | eath (Check only one) | | | | | | | |
| anding Physiath. | L 은 | 1 Yes 2 No | 1 Inpatient 2 | ER/Outpatient 3 ☐ I | | ce 6 Other (Specify) | | | | | | | |
| | ation | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio | | 28b. Time of Injury M | 28d. Describe how | injury occurred | | | | | | | |
| al or Att after de i Directo d in by t | Certification: To | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | | | | 28f. Location (Street and Number or Rural Route Num City or Town, State) | | | | | | | |
| ne Hospita n 24 hours ne Funera pletely fille | Medical C | 29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exam | nysician: To the best of my knominer: On the basis of examinated and manner stated. | owledge, death occurre ation and/or investigati | ed at the time, date and pla on, in my opinion, death oc | ce, and due to the cau curred at the time, date | se(s) and manner as stated. e and place, and due to the cause(s) | | | | | | |
| To the To | ž | 29b. Signature and title of certifier | | | 9c. License number | 29d | . Date signed (Month, Day, Year) | | | | | | |
| | | Mshan N. | Maloney | M.D. | AT243894 | 16 Se | ept 06,2008 | | | | | | |
| 11 | | 30. Name and address of person who | | | | | | | | | | | |
| 7 | | Tohai N. Malon | ey M.D., Union | Memorial | Huspital, M. | D. | | | | | | | |
| Sta Registi | | 75har N. Malon 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ature | | | | | | | | | |
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| | | | | ORIGINA | \L | | | | | | | | |
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08-06804 Gladys Ordonez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| adys Ordonez | State of Maryland / Department of Health and Mental Hygiene 2008 288 Certificate of Death Registrar | | | | | | | | | | | | } | | | | | | | |
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| ledical Examine | | a. Facility Name (if not | institution | | | | Fra | nco d | b. Ci |) r d tv. Tow | <u>one</u> | Z cation of D | | Septemb | | 4c. County | of Death | 122 | | |
| | | Howard County | | | | 11201) | | | | lumbi | | 4 | | | 1 | Howard | | | | |
| Funeral | 5 | . Social Security Numb | er (| . Sex | | 7. Age (| In yrs. la | st birthday) | _ | Jnder 1 | | If Under 2 | | 8. Date of E | | | Foreig | n | | |
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| the Maryland a or 28a-f show tified at once. | 1 | De. Street and Number | | | | | | | 10f. | Zip Co | de | | | | 10g. 0 | Citizen of V | /hat Cour | ntry? | | |
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| nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene, tit If item 27 is marked other than "natural", or items 23a or 28a-f she other transmite event, the Medical Examiner, must be notified at once TO Be Compilated by Eumeral Director | 2 | 19a. Informant's Name/ | Relationsh | ip (Type, | | | | | | | | | | ral Route N | | | wn, State | , Zip Co | ode') | |
| - p = E = | L | Mr. Jorge Ord | | 111 | - son | | 120h E | 5955 C Place of Dispo | | | | | TUMD | ia, MD | | +0 oc. Location | n - City or | Town, | State | |
| Ore, Mges I and 2 of Health | | 1 XX Burial 2 | | 3 🗌 F | temoval fr | om Stat | el o | rematory or o | her p | lace) | | - 1 | 9/1 | 1/08 | _F | llicot | t City | , ME |) | |
| Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr | | 4 Donation 5 | Other Spa | ecify: | | | GOO | | | | | of Facility | _ | - | | | | | | |
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| Physician | 1 | 23a. Part I. Enter the di failure. List only of | sease, or o | omplicati on each li | ons that c ne. | aused ti | he death. | Do not enter | he m | ode of o | lying, s | uch as car | diac or | respiratory a | arrest, | shock, or h | neart í | App | roximate Inte ween Onset Death | |
| /Medical xaminer | | mmediate Cause (Fina or condition resulting in | | | tiple Inj | | Tuence of | F)· | _ | _ | | | | | _ | | | - | Death | -1 |
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| 0, : be executed sician and burial - transit | dical | LINDENDED | | d | MENDED | | | | | | | | | | | | | + | | - |
| te be es | ğ | UNPENDED IF FEMALE: | | <u> </u> | 3c. If yes, | outcom | e of prea | nancv | - | _ | - | | | - | | 23d. Date | of deliver | y | | - |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director. | Physician/Me | 23b. Was decedent pre- past 12 months? | gnant in th | | Live | birth | | 2 _ F | etal d | | 3 | Ectopic | pregnar | ncy | - 1 | Month | | Day | Year | |
| Box e death c the atten ed for us | ysici | 1 Yes 2 V No | g Unk | nown g | | | ime of de | 5 C | ther | (Specify | y) | | | | | | | | | |
| that the deteched | | Part II. Other significa | ent conditi | ons cor | tributing t | o death | but not r | esulting in the | unde | rlying c | ause gi | ven in Par | t I. | | | | | | use of death | |
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| Divisior To the Hospital or Attend within 24 hours after death. To the Finneral Director: completely filled in by the | edical | (Check only one) 2 ✓ Me | edical Exa | nine#:On | the basis | of exan | nination a | ind/or investig | ation, | in my c | pinion, | death occ | urred a | t the time, d | ate and | d place, an | d due to t | he caus | e(s) | |
| To roo | ĕŀ | 29b. Signature and ti | e of certifie | | <u>manner</u> | stateu. | | | | 29c. | License | number | | | | 9d. Date s | | | ay, Year) | |
| 10 | | 1/ | // | 1 | | | | | | | O.C.N | Л.Е. | | | | Septemb | er 6, 2 | 800 | | |
| 1 | ľ | 30. Name and addless | | | | | | | 11 P | enn S | treet | Baltimo | ore. M | D 21201 | | | | | | |
| OCME Sta | | Mary G. Ripple | | | y Chief | | 's Signal | M | | | | Janana | | | | | | | | |
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| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | inicate or | Dealit | 2. Date of D | | | 3. Time of Death |
| | Physici /Medic | | | Guin | | | | Septer | nber 5 | , 2008 | 5:10 PM |
| | Examin Funeral Director | er | 5. Social Security Number 6. Sex 1 XM 2 F | Ail I | enter last birthday) Yrs. | 4b. City, Town, o | r Location of Dea Secole If Under 24 Hrs Hours Min | 8. Date of B | B | 9. Birthp Coun | NOC lace (State or Foreign try) Tennessee |
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| | th the or 28s | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen | of What Coun | try? |
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| がとう 21215-0036 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evan increases to include a | d by Funeral | 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 3 Never Married 3 Never Married 2 Never Married 3 Never Married 3 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 4 Never Ma | ² □No 19: | 56 ₁ 93 | □Yes 2. XNo | Hispanic Origin? (: an, Mexican, Puer Specify: | Specify Yes or N to Rican, etc.) | Spe | Race - Americ Black, White, e ecify: Whi | ite |
| 7, 7 | in 72 l n "nat | plete | 15. Decedent's Education (Specify only highest grade completed | | 16a. Decede (Give k life. D | ent's Usual Occup ind of work done O NOT use retire | cation during most of wo d) | rking | 16b. Kind o | of Business/Inc | dustry |
| | d with rgiene. er thai | Completed | Elementary/Secondary (0-12) College | (1-4or 5+) | | riceman | | | u.s | . Army | |
| ハ , Jな Maryland | be filed ntal Hygi ed other event, t | Be | 17. Father's Name (First, Middle, Last) | | | | | me (First, Middle | | name) | |
| ryla | should be fi and Mental I s marked of umatic eve | ٩ | Marvin O'Guin 19a. Informant's Name/Relationship (Type. Print) | | 10h Mailine | Addross (Street | Lois N | AcClanah | | uus Ctata Zin | Cadal |
| | and 2 s ealth ar n 27 is ner trau | | Elaine O'Guin (Wife) | | | Leland A | | | | | nd 21220 |
| しらないり Baltimore, Ma | of Hes of Hes fitem r othe | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from | 20b. P | | ition (Name of atory or other place | 1 | Date | | on - City or To | |
| A F | t. Pages tment of tant: If it | | 4 ☐ Donation 5 ☐ Other (Specify) | 1 State | yview C | rematory | 2 200 | 38 | Balti | more, N | Maryland |
| | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once. | | 21. Signature of Funeral Service Licensee | 5- | Br | in vota i | ki Funera Pastern A | Avenue | Essex, | Maryla | and 21221 |
| | Dharida | 80.78 | 23a. Part 1. Enter the disease or complications that shock, or heart failure. List only one cause on Immediate Cause (Final | each line. | 0 | | | ac or respiratory | arrest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | Or as a consequ | | neum | oniti: | 5 | | | |
| | Examiner | | 140 | ad IN | | ancer | un | hnown | 064 | in | |
| | ed sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | (or as a consequ | , | | | | 0 | | |
| Mrs. | tificate be executed g physician and as the burial-transit | xan | that initiated events c. | (or as a consequ | | rer | | | | | |
| 68760, | ite be iysicia ie buri | ledical I | d | | | | | | | | |
| | ± 50 % | Medi | IF FEMALE: | | | | | | | | |
| Division of Vital Records, P.O. Box | To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the funeral director. | Physician/M | 23b. Was decedent pregnant in the past 12 months? | utcome of pregnal birth 2□ Fetal gnant at time of de nown | death 3 🗌 | Ectopic pregnand Other (specify) | cy | | 23d. | . Date of delive Month | ery Day Year |
| S, | rires that signed to d be deta | by | Part II. Other significant conditions contributing to | leath but not resu | ilting in the und | derlying cause giv | en in Part I. | | | | ne cause of death? |
| Sor | w requir been s should | eted | | | - | | | | | lo 3□ Prob | |
| tal Re | ician: The law certificate has ector, page 2 s | • Completed | 25. Was case referred to medical | | | | | 1 □ Yes | opsy formed? 2 \(\sqrt{1}\) | prior to cor death? | psy findings available mpletion of cause of 2 □ No |
| f | vysician: nis certific director, | To Be | examiner? | Inpatient 2 I | ER/Outpatient | 3 □ DOA Oth | | ath <i>(Check only</i> Home 5 ☐ Res | | Other (Specif | v) |
| 0 4 | ding Physin. h. After this of funeral directions | D:uo | 27. Manner of Death 12 Natural 5 Pending (Mo. | e of Injury nth, Day, Year) | 28b. Time of Injury | 28c. Injui Wor | | 28d. Describe | | | 77 |
| Divisio | al or Attendi s after death. Il Director: A ed in by the fu | Certification: | 2 Accident investigation 3 Suicide 6 Could not be | e of Injury - At holding, etc. (Specify | me, farm, stre | M 1 □ | Yes 2□No | | (Street and Nown, State) | umber or Rura | l Route Number, |
| | To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b | edical | | ne best of my know basis of examinat nner stated. | wledge, death tion and/or inv | occurred at the ti estigation, in my o | me, date and place | ce, and due to the | e cause(s) and e, date and pla | d manner as s | tated. the cause(s) |
| | Vith To t | Σ | 29b. Signature and title of certifier | | | 29c. Licens | | | 29d. Date si | gned (Month, i | Day, Year) |
| | | | Fisher | | 00.1/5 | Ke. | 50000 | 2 | 09/0 | 5/200 | 18 |
| - | 10/1 | | 30. Name and address of person who completed cau | | 23a) (Type, P | rint) 1 Salua | re Drive | 2 An 11 | iman | o mh. | 21237 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | Registrar's Signat | | 23 | | 11000 | 1101 | 100-1 | 2.4 |

DHMH 17 Rev 1/2001

Deain,

Please Type or Print in Black Indelible in 8 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Perry Mae Johnnie /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** Hours Min 1 □ M 2 🔀 F Yrs. 212-26-0151 84 **Director** 07 NC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Modical Examiner must be neithed at 1 ☐XYes 2 ☐ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with U.S.A. 21212 Funeral 4707 Ivanhoe Ave 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Black Specify: δ 3 Widowed 4 □ Divorced Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
any Injury or other traumatic event, It e Madical Exp Baltimore, Maryland 21215-00 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fog College (1-4or 5+) Elementary/Secondary (0-12) London Frog Co. 12th grade Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be ပ Aaron Keith Vera Debram 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6857 Parsons Ave, Gwynn Oak, Md 21207
e of Disposition (Name of Date 20c. Location - City or Town, State Connie Butler-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 9/12/08 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, 21215 Md 23a. Part the Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ino candia Onset and Death Immediate Cause (Final disease or condition resulting in death) roba **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths?
1 Ves 2 VNo 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 certificate has autopsy perform 1 ☐Yes 2 ☐No 1 ☐ Yes Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate tiely filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 MER/Outpatient 3 □ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00058570 062008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

08-06810 Jer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ll Patillo | | State of Maryland / Department For State Certificate | | | 2008 2881 |
|---|----------------|---|---|---|---|
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Last) | or Death | Reg. No. | 3. Time of Death |
| ical Examin | | Jerrell Patillo | | Month Day September 5, | |
| | | 4a. Facility Name (if not institution, give street and number) 4900 Block of East Wabash and Lewin | 4b. City, Town, or Location of Dea Baltimore | ath 1 | 4c. County of Death |
| | 4 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | | Irs. 8. Date of Birth(Mi | M/DD/YYYY) 9. Birthplace (State or |
| Funeral Director | | 217-04-5652 t _{XX} M 2 F 27 | | April 16, | 1981 Foreign Country) DC |
| è | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L | ocation | | 10d. Inside City Limits |
| Maryland 28a-f show any d at once. | _ | MD | Baltimore | | 1 X Yes 2 No |
| larylar 18a-f s at on | Director | 10e. Street and Number | 10f. Zip Code | 10g. C | litizen of What Country? |
| ith the N 23a or 2 notified | | 3222 Milford Avenue | 21207 | | USA Block |
| death with the Maryland or items 23a or 28a-f sho must be notified at once. | Funeral | 11. Marital Status 1 X Never Married 2 Married Armed Forces? | Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue | specify Yes or No- irto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. | | 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year | Yes 2 X No specify: | | Specify: Black |
| urs aft tural" amine | d by | 15 Decedent's Education (Specify only highest grade completed) 16a. Dec | edent's Usual Occupation (Give kind | of work done 16t | . Kind of Business/Industry |
| 72 hou n "na al Exu | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | ng most of working life. DO NOT use | retired) | temp agency |
| ould be filed within 7 Mental Hygiene. marked other than c event, the Medica | mp | 12 | laborer 18 Mothodo No | ıme (First, Middle, Maid | 1 0 0 |
| filed of Hyging of the | | 17. Father's Name (First, Middle, Last) Gerald Gibson | | le Patillo-Per | |
| Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner | o Be | 19a, Informant's Name/Relationship (Type, Print) 19b. N | failing Address (Street and Number | | |
| nd 2 shoulth and m 27 is aumatic | | | 914 Grantley Road; Ba | | |
| permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum: | | | isposition (Name of cemetery, or other place) | | c. Location - City or Town, State |
| permit. Pages 1 ar Department of Hee Important: If ite | | 4 Donation 5 Other Specify: King Mem | | | andallstown, Maryland |
| rmit. epartm nports jury o | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility 638 N. Gilmor Street | wylie Fumeral | Maryland 21217 |
| | | 23a. Part I. Enter the disease, or complications that caused the death. Do not e | | - | shock, or heart Approximate Interva |
| hysician Medical | | failure. List only one cause on each line. | | | Between Onset and Death |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | |
| | | Sequentially list conditions, b | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause | | | |
| - ii | xan | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | |
| ecuted and transit | a E | d | | | |
| e be ex sician burial | ledical | UNPENDED AMENDED | | | 23d. Date of delivery |
| leath certificate be attending physici for use as the buri | <u>E</u> | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 2 2 2 2 2 2 2 2 | Fetal death 3 Ectopic pre | | Month Day Year |
| e death cer the attendi | sicia | 4 Pregnant at time of death 5 | Other (Specify) | | |
| t the dea by the a | Physician/M | Part II. Other significant conditions contributing to death but not resulting i | n the underlying cause given in Part I. | 23e. Did toba | cco use contribute to the cause of death? |
| res that t signed b be detact | ρ | Ú | | | 2 ✔ No 3 Probably 4 Unknown |
| The law require | Completed | | | 24a. Was an autopsy | 24b. Were autopsy findings availab prior to completion of cause of |
| e law r e has t ge 2 sh | ם | | | performe | d? death? |
| ysician: The his certificate director, page | | 25. Was case referred to medical | 26.Place of Death (Ch | eck only one) | |
| OI VILAI og Physician fter this certi neral director | To Be | numinos? | patient 3 DOA Other N | | sidence 6 🗸 Other: Scene |
| ling Phy After tl | | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) | me of Injury 28c. Injury at Work? | 28d. Describe hov Passenger au | v injury occurred to fixed object collision |
| Lal or Attendir rs after death. al Director: A led in by the fv | afi | 2 Accident Investigation | 100 20 | | eet and Number or Rural Route Number, Cit |
| pital or Attencours after death | Certification: | 3 Suicide 6 Could not be | n, street, factory, office building, etc. | or Town Stat | |
| ospita hours uneral | | 29a Certifier | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical | (Check only one) 2 Medical Examiner:On the basis of examination and/or inv | estigation, in my opinion, death occur | red at the time, date an | d place, and due to the cause(s) |
| To To | Mec | and manner stated. 29b. Signature and title of certifier | 29c. License number | 2 | 9d. Date signed (Month, Day, Year) |
| | | Moulante Mrs. Theel | O.C.M.E. | | September 6, 2008 |
| 5 | | 30. Name and address of person who completed cause of death (Item 23a) | | | |
| 7 | | Marganta Koron M.D. , toolotak M. | 11 Penn Street, Baltimore, N | MD 21201 | |
| | State | A A O OCCO W. | is of | | |
| Regi | | | CINIAI | | |
| MH 17 Rev 1/ | /2001 | ORI | GINAL | | OCME |

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State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Day 05 **Physician** a M 2008 11:30 Mary C. Pennoni /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A 3819 Mary Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 04/06/1924 Pennsylvania 84 Director 200-16-0186 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City. Town or Location fshow 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Expaning must be notified at 1 ¥Yes 2 ☐ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3819 Mary Avenue 21206 death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 X No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roselda Unknown Clementi Cassotti ပ a Informant's Name/Relationship (Type. Print) Olderico Olderic P. Pennoni, Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3819 Mary Avenue, Baltimore, MD 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith 09/10/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Leonard J. Ruck, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sirpnosell 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Zheme! **Physician** YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The Ather attended the death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the inneral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Year 5 Other (specify) 1 Tyes 2 Turo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

State Registrar

3

mo 1+more Ka 76UZ Belour 31. Date filed (Month, Day, Year) SEP 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Physician 910120 4. Price /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltemore Northwest Season Hospice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Months 60 Director 213-52-3419 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examinat must be notified at any lighty or other traumatic event, the Medical Examinat must be notified at any lights. mo Director Baltimore 10e. Street and Number 10f. Zip Code 3104 Garrison Funeral 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XIIII Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) R. Alelia Buller-Lake James 2 19a. Informant's Name/Relationship (Type. Print) 19h Alelia Baker-Lake 3 20a. Method of Disposition 20b. Place o cemete 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bay 21. Signature of Funeral Service Licensee onald 1 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Motastatic /Medical Die to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine burial-transit ag ? Due to (or as a consequence Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

32. Registrar's Signature

Part II. Other significant conditions contributing to death but not resulting in

30. Name and address of person who completed cause of death (item 23a)

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

| me/Relationship (| Type. Print) | | 19b. Mailing Addr | ess (S | Street and Number or Ru | ıral R | oute Numbe | er, City | or Town, State | , Zip Code) | |
|--|---|----------------------|---|--------------------|--|--------|----------------------------|-------------------|----------------------------------|--|------------------------------|
| Baker. | - Lake | | 3104 G | rai | rrison Blv | d. | Ball | ten | rose M | D. 2/2 | 16 |
| osition Cremation 3 Other (Special | Removal from State (fy) | C6 | ace of Disposition (femetery, crematory c | or othe | matry Scrt | Date | 2008 | Du | ocation - City o | Man | land. |
| eral Service Liceral Liceral Service Licerate Liceral Service Liceral Service Liceral Service Liceral Service | rsee Groupen | | 22. Name | nand. | Address of acility LUA Cra Eved 144 | ys | pass | eun. | eral S | evic | 229 |
| e disease, or com tfailure. List only final | plications that caused to one cause on each line a. Due to (or as a | sta | . Do not enter the n | | of dying, such as cardiac | or re | | | _ | Approxir Interval | |
| ditions, nediate ying ijury | b. Due to (or as a | consequ | ence of): | | | | | | | | |
| ast | C Due to (or as a | consequ | ence of): | | | | | | | | |
| | d | | | | | | | | | | |
| pregnant nonths? No | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t | Fetal | death 3 Ectopi | | | | | | 23d. Date of d Month | lelivery Day | Year |
| cant conditions | contributing to death but | not resu | Iting in the underlyin | g cau | se given in Part I. | | | | use contribute | to the cause Probably 4 | |
| | | | | | | | | | prior to death' | autopsy findir completion es 2 \(\sigma\) No | ngs available of cause of |
| ed to medical | | | | | 26. Place of Dea | | | | | | SCINS |
| lo | Hospital: 1 ☐ Inpatien | 2 🗆 🛚 | ER/Outpatient 3 ☐ | DOA | Other: 4 Nursing H | lome | 5 ☐ Resid | lence | 6 爲Other (Sp | ecity) ito | SPICE |
| 5 Pending investigation | 28a. Date of Injury (Month, Day, | Year) | 28b. Time of Injury M | 280 | l Injury at Work? 1 ☐ Yes 2 ☐ No | | . Describe h | | | | |
| 6 Could not b determined | 28e. Place of Injury building, etc. | - At hor (Specify | me, farm, street, fact | ory, o | ffice | 28f. | Location (S City or Tow | Street a | nd Number or i e) | Rural Route N | lumber, |
| Certifying Pl | nysician: To the best of niner: On the basis of a and manner state | xaminat | vledge, death occurr ion and/or investigat | red at tion, ir | the time, date and place my opinion, death occu | e, and | d due to the at the time, | cause(date ar | s) and manner od place, and d | as stated. ue to the caus | se(s) |
| tle of certifier | Pieu | | | | icense number -45931 | | | | ate signed (Mo | | |
| ss of person who | completed cause of dea | th (Item | 23a) (Type, Print) 835 Sm | ut | h Avenue | | Suite | 20 | 13 Ba | itime | MD |
| | | | | | | | | | | | |

2. Date of Death September Day

8. Date of Birth (Month, Day, Year)

Oct 28,1947

0550 M

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

Yes 2 ☐ No

2008

Baetimore

14. Race - American Indian, Black, White, etc.

Specify: Black

WR Grace

4c. County of Death

10g. Citizen of What Country? U.SA,

16b. Kind of Business/Industry

To the Hospital or Attending Physician: The law requires that the death certificate be exec within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician am completely filled in by the funeral director, page 2 should be detached for use as the burial-rite or the state of the state o Physician/Medical <u>م</u> Completed Be Medical Certification: To

State Registrar

□Yes 2□No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

) oburan

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 3:00 AM ARSONS SEPTEMBER UCILLE 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 113 OAK STREET BALTIMORE TURNER STATION Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Year Days Hours Months 1 M 2 XF 77 249-40-6308 Yrs 6-3-1931 SC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE TURNER STATION 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 and of Health and Mental Hygiene.
Intel if item 27 is marked other than "natural", or Items 23a or 3 and 1 an 113 OAK STREET 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABETH JACKSON ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARNETT PARSONS/HUSBAND BALTIMORE, MD Department of Health Important: If item 27 any injury or other tr 113 OAK ST. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Verial 2 Cremation 3 Removal from State HOLLY HILL MEM. GRDNS 4 □ Donation 5 □ Other (Specify) 9-13-08 MIDDLE RIVER, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. any ir BALTIMORE, MD ames 1701-31 LAURENS ST. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 30 YEAR PARKINSON'S DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p 88 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f o. 9□Unknown ٦ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 3 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 No Jas page 2 certificate I 1□ Yes **Division or Vital** Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA ဥ 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 505 BAYVIEN CIRCLE BALTIMORE HAYASH HOPKINS 3 Registrar's Signature 31. Date filed (Month, Day, Year) State SFP 0 9 2008 Registrar

| | | | Pleas | se Type or Prin | | | | | - | | | | |
|--|-------------------|---|------------------------------|---|--------------------|------------------------|--|--|--|---------------------|-------------------------------------|---|----------|
| | | For State Registrar | | State of Ma | arylan | | epartment of F Dertificate of | | Mental Hy | giene Reg. No | 0000 | 2881 | 8 |
| Dhysisia | | Decedent's Name (| First, Middle, | Last) | | | | | 2. Date of De | | ~~~ | 3. Time of Death | n O |
| Physicia /Medic | | | | LaRue | Sc | hnaı | 2010 | rrish | Sept. | 3, | 2008 | 9:30 P | M |
| Examine | er | | | give street and number) | T17Th | T.C. | | r Location of Death | | 4c. | County of Dea | | |
| Funeral | | 5. Social Security Num | | 6. Sex 7. Ag | IVII e (In yrs. | | | IMINSTEI If Under 24 Hrs. Hours Min. | | rth av. Year) | CARROI 9. Bir | لار thplace <i>(Stat</i> e o <i>r F</i> ore ountry) | eign |
| Director | | 220-05-0 Usual Residence of D | | 1□M 2XF | 88 | 3 Yr | s. Worth Days | Tiodio Iviiii | 7/26 | | | RYLAND | |
| ryland show | _ | | 0b. County | | 10c. Cit | y, Town o | r Location | | | | | 10d. Inside City Lim | |
| ith the Marylan or 28a-f show | Director | MD 10e. Street and Numb | CARRO | | WI | ESTM | INSTER | | | 10- 00 | | 1X Yes 2 □ I | No |
| 3a or | ا ق | | | RD., ROOI | и 21 | 3 | 10f. Zip Code 211 | 57 | | Tog. Cit | tizen of What Co | outility? | |
| r deat | Funeral | 11. Marital Status | | 12. Was Decedent I Armed Forces? | | | 13. Was Decedent of I If Yes, specify Cub | | pecify Yes or No o Rican, etc.) |)- | 14. Race - Ame Black, Whit | | |
| should be filed within 72 hours after death with the Maryland and Marial Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, I'm Madical Evarrings must be notified at | Ŕ | 1 ☐ Never Married 3 ☑ Widowed 4 | | ed 1 □Yes 2 ☑ 1 If Yes, Give Year or Dates: | 40 | | 1 □Yes 2 No | Specify: | | | Specific | HITE | |
| 72 hou | Completed | 1: (Specify | 5. Decedent's | s Education grade completed) | | 16a. D | ecedent's Usual Occup | oation | kina | 16b. K | ind of Business | | |
| within ene. than " | duc | Elementary/Second | | College (1-4or 5 | +) | i 'ii | Give kind of work done fe. DO NOT use retire TEACH | | King | רום | UCATIO |)M | |
| e filed al Hygi other /ent, I | Be | 17. Father's Name (Fi | rst, Middle, L | ast) | | <u></u> | THACII | 18. Mother's Nan | ne (First, Middle | | | 711 | |
| ould be Menta arked | ام ا | | | LEWIS | | SCHN | AUBLE | GRACI | ₹ | W | ILLIAN | 1S | |
| d 2 sh Ith and 17 is m traum | | 19a. Informant's Nam | | | TA7 | | lailing Address (Street | | | | | | |
| is 1 and of Health Item 27 other to | ŀ | 20a. Method of Dispos | sition | | | | 07 PATRIC isposition (Name of crematory or other place | | Date | | ocation - City or | | |
| Pages ment of lant: If Ite | | 1 ☑ Burial 2 ☐ 0 4 ☐ Donation 5 | | 3 □ Removal from State ecify) M | | | SANT CEM | 9/7/ | /08 | GAM | BER, M | 1D | |
| permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, I'm Medical Evantione. | | 21 Signature of Fune | ral Service Li | icensee | | | 22. Name and Addre | ess of Facility FLI | ETCHER | FUN | ERAL F | HOME, P.A | 4 . |
| | | 23a. Part 1. Enter the | disease, or c | complications that caused | the death | n. Do not | | AIN ST. | | | STER, M | Approximate Interval Between | |
| Physician | | Immediate Cause (Fi | | nly one cause on each lir | | scui | lar accid | ent | | | | Interval Between Onset and Death three we | |
| /Medical Examiner | | resulting in death) | 1 | Due to (or as | | | | <u> </u> | | | | CITICO WC | CIV |
| ->> (| Jer | Sequentially list condition if any, leading to immediate. Enter Underly Cause (Disease or inj | tions, ediate | b Due to (or as | a consequ | uence of) | | | | | | | |
| be executed sician and burial-transit | Examiner | Cause (Disease or inj that initiated events resulting in death) Las | | c | | | | | | | | | |
| be licia bur | | rooding in dodain Eac | ^ | Due to (or as | a consequ | uence ot) | | | | | | | |
| rtificat ng phy as the | Medic | IF FEMALE: | | d | - | | | | | | | | |
| The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the | Physician/Medical | 23b. Was decedent point the past 12 mg | onths? | 23c. If yes, outcome | 2 Feta | l death | 3 Ectopic pregnance | су | | | 23d. Date of de | livery Day Year | |
| that the denetate by the detached | hysic | 1 ☐ Yes 2 ☐ N 9 ☐ Unknown | 10 | 4 ☐ Pregnant a 9 ☐ Unknown | t urne or d | leath | 5 ☐ Other (specify) _ | | | | | | |
| es that igned I be det | by P | Part II. Other significa | ant condition | ns contributing to death be | ut not resu | ulting in th | ne underlying cause giv | ven in Part I. | 23e. Did | tobacco (| use contribute to | o the cause of death? | <u> </u> |
| w require been si should b | eted | | | | | | | | 1 🗆 | Yes 2 | © No 3 □ P | robably 4 🗆 Unkno | wn |
| he law e has l | Completed | | | | | | | | 24a. Was auto perfe | | | utopsy findings availal completion of cause of | |
| | Be C | 25. Was case referred | to medical | | | | | 26. Place of Dea | 1 □ Yes | 2 No | | s 2 No | |
| Physician: this certific ral director, [| | examiner? |) | | | | atient 3 DOA Oth | ner: 4 Nursing H | lome 5 Res | idence | 6 ✓ Other (Spe | ASSISTE | D |
| ding h. After fune | Certification: To | 27. Manner of Death 1 ☑ Natural 2 ☐ Accident | 5 Pending | | ry y, Year) | 28b. Tim Inju | iry Wor | ryat k?]Yes 2 □No | 28d. Describe | how injur | ry occurred | LIVING | |
| al or Attendir after death. I Director: At d in by the fur | tifica | | 6 Could no determin | ot be 280 Place of Init | ury - At ho | ome, farm | , street, factory, office | | 28f. Location (| Street ar | nd Number or R | ural Route Number, | |
| pital or Attenous after deat leral Director: filled in by the | | One Continue all | X | | | | | | | | | | |
| To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by | edical | 29a. Certifier 1 (Check only 2 one) | _4 Certifying ☐ Medical E | Physician: To the best xaminer: On the basis o and manner sta | f examina | wledge, o tion and/ | death occurred at the ti or investigation, in my o | ime, date and place opinion, death occu | e, and due to the irred at the time | cause(s date and | s) and manner a d place, and due | s stated. e to the cause(s) | |
| To th Vithir COmp | ĕ. | 29b. Signature and titl | e of certifier | 1.0 | - | | 29c. Licens | | | | ite signed (Mon | | |
| | - | 7600 | m) | 17/ Junh | en | 2 | 0 | 7040 | \$ | epte | emper | 5, 2008 | |
| 12 | - 1 | 30. Name and address Howard G | | tho completed cause of d | | | rpe, Print) Ishington | Height | s Medi | cal | Cente | r, | |
| Stat | | 31. Date filed (Month, | - | 32. Registra | ar's Signa | ture _ | | | inster | | | | |
| Registra | r . | SEP | 0 9 20 | 08 flower | ST | Se Di | who | | | | | | |

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other traumatic event; the once.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

Director

Funeral

þ

Completed

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | lications that caused the death. Do not enter the one cause on each line. | | respiratory arrest, | Approximate Interval Between Onset and Death | | | | | |
|-------------------------------|--|---|--|--|--|--|--|--|--|--|
| | Immediate Cause (Final disease or condition | · cardial | arrest | | 1 day | | | | | |
| | resulting in death) | Due to (or as a consequence of): | | | 8 | | | | | |
| niner | Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury | b | | | | | | | | |
| cal Exar | that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | | | | | |
| by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | | pic pregnancy er (specify) | 23d. Date of Month | delivery Day Year | | | | | |
| d by Ph | Part II. Other significant conditions co | ontributing to death but not resulting in the underly | ving cause given in Part I. | 23e. Did tobacco use contribut | e to the cause of death?] Probably —4 □Unknowr | | | | | |
| Completed | | 1 | | 24a. Was an 24b. Wers autopsy performed? deat | | | | | | |
| Be C | 25. Was case referred to medical | | 26. Place of Death | (Check only one) | | | | | | |
| 0 | examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 | ☐ DOA Other: 4☐ Nursing Hor | ne 5 Residence 6 🗆 Other (8 | Specify) | | | | | |
| tion: T | 27. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investigation | of Death 28a. Date of Injury 28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how in Work? 1 Yes 2 No 28d. Describe how in Work? 1 Yes 2 No 28d. Describe how in Work? 28d. Describe | | | | | | | | |
| Medical Certification: | | | | | | | | | | |
| dical C | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | ysiclan: To the best of my knowledge, death occ nlner: On the basis of examination and/or investi- and manner stated. | curred at the time, date and place, a gation, in my opinion, death occurr | and due to the cause(s) and manne ed at the time, date and place, and | er as stated. due to the cause(s) | | | | | |
| Me | 29b. Signature and title of certifier | 2 0 1 | 29c. License number | 29d. Date signed (M | Ionth, Day, Year) | | | | | |

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Brens &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

716 MAIDEN

3/322 sept 4/6-2008

CHOICE IN CATONSVILLE MY 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviaho, perpartment of the entire and 9 Mental Pavoleties Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eleanor M. Rehak Sept 2008 12:30AM /Medical 4bEdgewer ecation of Death
Dundalk 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore 7342 Waldman Ave. Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F 74 Director 1-13-1934 212-30-9906 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examinar must be notified at Edgemere 1 XYes 2 No Director Dundalk MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21219 7342 Waldman Avenue Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Ft. Howard VA Hosp. 10 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Sophie J. Dziklinski Vernon Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any injury or other trau 7342 Waldman Ave, Edgemere, MD 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 9-5-08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton FuneralHome 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 21222 PA, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year **Physician** metastasio /Medical **Examiner** Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier D45390 39. Name and address of person who completed cause of death (Item 2Ba) (Type, Print) Rad # 208 = 12 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 0 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 2882 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 2008 10:05 a^M David **Allen** Richardson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 734 Lake Path Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, AUG 9 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XM 2 F Months 214-56-0466 58 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show the notified at 10a. State 10b. County 1 ☐ Yes 2X No **Funeral Director** MD Anne Arundel Crownsville 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ms 23a USA 734 Lake Path 21032 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify Specify: ģ White 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filled within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany or other traumatic event, the Medical Ang." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Window Installer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Richardson Yetta UNK ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Devin Strumsky - daughter 1305 Purnell Road, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/6/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. Williams ²²Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ar Datoc disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred **Natural** 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed knus after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral D

completely filled i

Ze MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Dr. John Christie, MD, 2661 Riva Road, Suite 610, Annapolis, MD

State Registrar

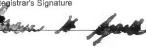
Medical

29a. Certifier

(Check only one)

29b. Signature and

31. Date filed (Month, Day, Year) 32. Registrar's Signature SÉP 0



ORIGINAL

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medice Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number P50605 29d. Date signed (Month, Day, Year)

| 8-06707 | | Please Type or Print in Black Indelible Ink. Ensure All Copi | |
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| homas W Ring | _ | | lygiene 2008 2882 |
| | | Registrar Certificate of Death | Reg. No. 2. Date of Death 3. Time of Death |
| Physici Medical Exami | ٠ | 11 11 11 - 22 - 10 | Month Day Year 1115 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea | |
| | | Union Memorial Hospital Baltimore | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H | Egraign |
| Director | 2 | 1 X 2 F 57 Yrs. Months Days Hours M | 12-5-1950 Country) 10 |
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| v any | | 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| Maryland 28a-f show 1 at once. | 5 | MD Baltimore | 1 Kes 2 No |
| Mary 28a- | Director | 10e. Street and Number | 10g. Citizen of What Country? |
| 5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at ouce. | | | USA |
| th wit ems | Funeral | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (1) If Yes, specify Cuban, Mexican, Puer | |
| er dea | 교 | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: | Specify: Black |
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| ID 212 should be and Menta 7 is marke | ٩ | $A \cap A \cap A \cap A \cap A \cap A \cap A \cap A \cap A \cap A \cap$ | r Rural Route Number, City or Town, State, Zip Code) |
| nd 2 | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, | Date 20c. Location - City or Town, State |
| Baltimore bermit. Pages 1 a Department of He important: If ite | | 1 XBurial 2 Cremation 3 Removal from State crematory or other place) | 18/2008/2001 MD |
| e ta la la la la la la la la la la la la la | | 4 Donation 5 Other Specify: 1 MATOURY CAPTURE 121-Sign ture of Funeral Service Licenses 2 N ne an Address of Family | Francisco Societ |
| Balt permit. Depart Impor injury | Ų ij | Janen C. Streeme Jorde 1 Del | 71 Rato MD 2212 |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac | c or respiratory arrest, shock, or heart Approximate Interval Between Onset and |
| /Medical xaminer | | failure. List only one cause on each line. Methadone intoxication Immediate Cause (Final disease a. Hypertensive Atheroscleretic Cardiovascular Disease | Death |
| Kaillilei | | or condition resulting in death) Due to (or as a consequence of): | |
| | ᆸ | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | · · · · · · · · · · · · · · · · · · · |
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| executed an and all - transit | cal | UNPENDED X AMENDED 23a,PII,2/,28a-t, perME, g884 | 10/2/08 TT |
| | ledi | IF FEMALE: 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
| 387 rtifica ing pl | sician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg | |
| OX (eath ce attend for use | sici | 1 Yes 2 No 9 Unknown Q Unknown 5 Other (Specify) | |
| D. B(t the de by the ached f | Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |
| ords, P.O. w requires that th as been signed by should be detach | | | 1 Yes 2 No 3 Probably 4 Unknown |
| ds, equire een si | Completed by | | 24a. Was an 24b. Were autopsy findings available |
| COF : law r : has b e 2 sh | ם | (i) | autopsy prior to completion of cause of death? |
| tal Rec | | | 1 Yes 2 No 1 Yes 2 No |
| Vital hysician: this certifi Il director, | o Be | examiner? Hospital: 4 Innetion: 3 P. EP/Outration: 3 DOA Other, Nur | sing Home 5 Residence 6 Other: |
| of V ling Phy After th funeral o | 1 | 27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work? | 28d. Describe how injury occurred |
| OD cendin eath or: A | tio | Natural 5 Pending 9/2/08 9:40 am 1 Yes 2 X No | unknown |
| Division of Vital Records, tal or Attending Physician: The law requing after death all Director: After this certificate has been siled in by the funeral director, page 2 should be | iji | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. | 28f. Location (Street and Number or Rural Route Number, City |
| Dital ours at eral E | Certification: | 4 Homicide determined (Specify) dialysis center | or Town, State) 3303 Chestnut Ave. Baltimore, MD |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | | | and due to the cause(s) and manner as stated. |
| Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier 29c. License number | 29d. Date signed (Month, Day, Year) |
| | 2 | 29b. Signature and title of certifier 29c. License number O.C.M.E. | September 3, 2008 |
| | | Poteth - Well m | OCACHIDO: 0, 2000 |
| 5 | | 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltim | ore, MD 21201 |
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| - | /Medic | cal | Emogen | | sett | | | | and continued Dooth | Septem | | 5, 2008 | 8:55 | AM |
| | Examin | er | | Mar i s | on, give street and nu | mber) | | Timoniu | or Location of Death | 1 | | Itimore | 11 | |
| | Funeral | | 5. Social Security | | 6. Sex | 7. Age (In yrs. | last birthday |) If Under 1 Yea | r If Under 24 Hrs. | 8. Date of Bi | | 9. Birt | thplace (State | or Foreign |
| | Director | | 218-22 | | 1 □ M 2 🕅 F | 80 | Yrs. | Months Day | S Hours Will. | 8. Date of Bi | ay, Year) 19 | 028 | Vir | ginia |
| | land wc | | Usua! Residence 10a. State | of Decedent 10b. County | / | 10c. C | ity, Town or L | ocation | | | | | 10d. Inside C | City Limits |
| | Mary a-f sh | tor | MD | Harfo | ord | Abi | ngdon | | | | | | 1 □Yes | No No |
| | or 28: | Dire | 10e. Street and | | | | | 10f. Zip Code | | | - | izen of What Co | untry? | |
| | s 23a | rail | 110 Ed | ith Sto | ne Drive | | | 21009 | | | USA | 14.5 | to a factor | |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evancial trausities healthful at once. | by Funeral Director | | s arried 2□ Ma I 4□ Divorce | rried Armed Fo | ve | J.S. 13 | . Was Decedent of If Yes, specify Cu 1 □ Yes 2 🛚 N | f Hispanic Origin? (S uban, Mexican, Puert o <i>Specify:</i> | o Rican, etc.) | 0- | 14. Race - Ame Black, White Specify: | | |
| 5-0 | 72 ho 'natur | letec | (S) | 15. Decede pecify only high | nt's Education est grade completed) | | 16a. Dec | edent's Usual Occ e kind of work don | cupation ne during most of work red) | king | | ind of Business | | |
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| Maryland | Menta Menta rked ric ev | To B | Homer | S1emp |) | | | | Cleo G | reene | | | | |
| lar) | 2 short and 1 small smal | . 0 | | | ship (Type. Print) | | | | et and Number or Ru | | | | | |
| | and lealth m 27 | | | eth Met | zbower / | | | | tone Driv | e; Abin Date | | , MD 210 ocation - City or | | |
| Baltimore, | ages intofficer in the intofficer in the intofficer of int | | 20a. Method of I | 2 Cremation | 3 Removal from | State | - | oosition (Name of ematory or other p | | | | | | |
| Ħ | artme artme ortani injun | | 4∐ Donatio | ∫ 5 □ Other (| | Pa | | Cemeter 22. Name and Add | | 08 | | k ville, 050 Yor | | |
| ñ | Depar Depar Impor any ir | l O |) | earle | lux | | | | on Funera | | T | owson, | |)4 |
| | Physician | 8 10 | 23a. Part 1. Ente shock, or h Immediate Caus disease or cond resulting in deat | se (Final ition | or complications that of the cause on each | aused the dea | th. Do not e | nter the mode of d | lying, such as cardiad | or respiratory | arrest, | | Approxima Interval Be Onset and | etween |
| 4 | /Medical Examiner | | resulting in deal | , | Due to | (or as a conse | quence of): | | | | | | | |
| | | Jer | Sequentially list if any, leading to | conditions, immediate | b | (or as a conse | quence of): | | | | | | | |
| St | ificate be executed g physician and as the burial-transit | edical Examiner | Sequentially list if any, leading to cause. Enter Ur Cause (Disease that initiated every list and the cause) | or injury | С | | | | | | | | | |
| 60, | be exection sician sician sicial- | E | resulting in deat | i) Last | Due to | (or as a conse | quence of): | | | | | | | |
| 68760, | ificate g physi is the l | dic | | | d | | | | | | | | | |
| O. Box (| death cert e attendin d for use a | Physician/Me | IF FEMALE: 23b. Was deced in the past 1 □ Yes 9 □ Unkno | 12 months? 2 X No | | birth 2☐Fet nant at time of | al death 3 | ☐ Ectopic pregna ☐ Other (specify) | | | | 23d. Date of de Month | elivery Day | Year |
| Д. | The law requires that the date has been signed by the page 2 should be detached | by Ph | Part II. Other sig | nificant condit | tions contributing to d | eath but not re | sulting in the | underlying cause | given in Part I. | 23e. Did | tobacco | use contribute t | o the cause of | death? |
| of Vital Records, | equires en sig ould be | ed b | | | | | | | | 1 🗆 | Yes 2 | □ No 3□ P | robably 4 |] Unknown |
| ecc | law re las be | Completed | | | | | | | | 24a. Was | yago | prior to | utopsy findings completion of | s available cause of |
| E B | Physician: The law this certificate has trail director, page 2 sl | Con | | | | | | | | | formed? 2 X No | death? 1 ☐ Yes | s 2□No | |
| Vita | Physician: this certific ral director, I | Be | 25. Was case re examiner? | | Hospital: | | 7 | | 26. Place of Dea | | | | | |
| of | | n: To | 1 Yes 2 27. Manner of D | - | 28a. Date | | 28b. Time | of 28c. In | 4 L Nursing F | lome 5 ☐ Res 28d. Describe | | 6XOther (Spenry occurred | ecify) HOS | SPICE |
| ion | Attending r death. sctor: After by the fune | atio | 1 X Natural 2 ☐ Acciden | 5 ☐ Pendi inves | ing (Mor tigation | th, Day, Year) | Injury | | /ork? □Yes 2□No | | | | | |
| Division | | Certification: To | 3 ☐ Suicide 4 ☐ Homicid | 6 □ Coufe deter | mined 200, Place | of Injury - At I ing, etc. (Spec | nome, farm, s | treet, factory, offic | е | | (Street ar | nd Number or Fi e) | ural Route Nu | mber, |
| | To the Hospital or within 24 hours afte To the Funeral Direction completely filled in | Medical | 29a. Certifier (Check only one) | | ing Physician: To the last Examiner: On the last mar | | | investigation, in m | y opinion, death occu | | e, date an | nd place, and du | e to the cause | (s) |
| | 7 with 00 00 00 00 00 00 00 00 00 00 00 00 00 | N | 29b. Signature à | nd title of certifi | The V | Y | 141 | 10 29c. Lice | ense number | 0 | 29d. Da | ete signed (Mon | th, Day, Yaar) | 2008 |
| | 10 | | | | n who completed cau | | 1 | | | TID: | |) | | |
| | Sta | te | DR • ER 31. Date filed (N | | r) 32. F | Registrar's Sigr | nature | VALLEY R | D. TIMON | IUM, MD | 2109 | 93 | | |
| | Registi | | | | | m B | | de | | | | | | |
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SEPTEMBER 5, 2008

EMOGENE RIESETT

ORIGINAL

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 28824 Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3:48 PM 2008 SEP GERARI) RIOUX /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia COUNTY GENERAL HOWALD HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex B. Date of Birth **FEB**onth, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours ₩XM 2□F May 24,1931 220-34-4586 Canada Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examiner must handle one. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXXNo Director MD Howard Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8455 Murphy Road 20723 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 Tyes 2 XNo Specify: Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Barber Barber Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philippe Rioux Alexina Morneau ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daugh-Linda Marie Cecile Rioux/ ter 4900 Blackfoot Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Sept.11, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 2008 Washington, DC 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kein Skila /M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MAYS disease or condition resulting in death) AMUXIC ENLEPHATOPATHY /Medical Due to (or as a consequence of): Examiner 5 nAy AWTE MYJEANDIAL Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical as IF FEMALE: if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | robably 4 | Unknown MULTINGARUT DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ ★6 24a. Was an SUM ZOAFRELTINE 9155RD FR autopsy performed 2 **3 K**0 HYPERTENSION 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide (x) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Darlingon 6,200B N36974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 09

2008

CownsiA mo 21044

DAVID O NYANTOM MD. 10724 47TLE PATURENT PARKING

32. Registrar's Signature

CARLOR.

| | | | Please Type or P | | | | _ | _ | | | |
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| | | | For State of State Are Registrar | Maryland / Dep | artment of t e <i>rtificate of</i> | | | giene Reg. No.2 | 28825 | | |
| | | | Decedent's Name (First, Middle, Last) | | | | 2. Date of De | | 3. Time of Death | | |
| | Physici /Medio | | MARIAN | | THENBERG | | SEPTEMB | EPTEMBER 7 2008 7:25 A | | | |
| | Examin | ier | 4a. Facility Name (If not institution, give street and num MILFORD MANOR NURSING I | | BALTIMO | RF | | 4c. County of Dea | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7 | . Age (In yrs. last birthday | | | 8. Date of Bir (Month, Da | th 9. Bir | thplace (State or Foreign | | |
| | Director | | Usual Residence of Decedent | 91 Yrs. | | | 02/18/ | 1917 | MD | | |
| | show | _ | 10a. State 10b. County | 10c. City, Town or L | | | | | 10d. Inside City Limits 1 □ Yes 2 No | | |
| | the Ma 28a-f | Director | MD BALTIMORE 10e. Street and Number | B | ALTIMORE 10f. Zip Code | | | 10g. Citizen of What Co | | | |
| | h with | | 2440 FOREST GREEN ROAD | | | 1209 | | USA | · | | |
| | tems terms | Funeral | Armed Ford | ent Ever in U.S. 13. | . Was Decedent of I | Hispanic Origin? (Spe an, Mexican, Puerto | ecify Yes or No Rican, etc.) | 14. Race - Am Black, Whit | | | |
| 5-0036 | 2 hours after death with the Maryland atural", or items 23a or 28a-f show call Examiner must be notified at | þ | 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dat | | 1 □Yes 2X No | | Specify: WHITE | | | | |
| 2 | 72 ina | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Giv | edent's Usual Occu e kind of work done | during most of worki | ng | 16b. Kind of Business | /Industry | | |
| 717 | filed within Hygiene. ither than ' | ошр | Elementary/Secondary (0-12) College (1-4 | lor 5+) | DO NOT use retire HOMEMAKE | | | OWN HOME | | | |
| ם | be filed htal Hyg d other event, | BeC | 17. Father's Name (First, Middle, Last) HARRY | POT | TC | | | , Maiden Surname) | I & D T I \ O | | |
| ryla | hould be marked marked marked | ြ | 19a. Informant's Name/Relationship (Type. Print) | | | REBECCA | | er, City or Town, State, | IÁPIRO Zio Code) | | |
| <u>z</u> | s 1 and 2 should f Health and Mer item 27 Is marke other traumatic | | MARSHA LAYTON / DAUGHTER | | • | GREEN RD. | | | 21209 | | |
| ore, | Pages 1 and of He | | 20a. Method of Disposition 1 Description 1 Removal from St | 20b. Place of Disp cemetery, cre | osition (Name of ematory or other pla | ce) | ate | 20c. Location - City or | | | |
| altimo | # 문문구 . | | 4 ☐ Donation 5 ☐ Other (Specify) | IIAKI OKD C | JEWISH CE | NTER09/08/ | 1 | ROSEDALE NSON & BROS | | | |
| מ | Depa Impo any ir | | 21. Signature of Funeral Service Licensee | | | | | PIKESVILLE | | | |
| | | | 23a. Part 1. Enter the disease, or complications that cat shock, or heart failure. List only one cause on ear | used the death. Do not en | nter the mode of dyi | ng, such as cardiac o | or respiratory a | ırrest, | Approximate Interval Between Onse and Death | | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | nd Sto | us be | wente | 7 | | Chlinery | | |
| | Examiner | | | r as a consequence of): | 0 | | | | | | |
| 1 | sit ed | iner | | as a consequence of): | | | | | | | |
| , | executed in and ial-transit | Examiner | that initiated events | as a consequence of): | | | | | | | |
| 00/00 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | dical | | | | | | | | | |
| o xoa | certific nding p | Physician/Medica | | ome of pregnancy | | | | 23d. Date of de | livery | | |
| Ŏ | death he atte | sicia | in the past 12 mooths? 1 ☐ Live bit 1 ☐ Yes 2 ☐ No 4 ☐ Pregna | nt at time of death 5 | ☐ Ectopic pregnand ☐ Other (specify) _ | | | Month | Day Year | | |
| ŗ | that the ed by t detach | | 9 ☐ Unknown Part II. Other significant conditions contributing to dea | | underlying cause giv | ven in Part I. | 23e. Did t | tobacco use contribute t | o the cause of death? | | |
| cords, | quires en sign uld be | sd by | | | | | 1 🗆 | Yes 2. No 3. P | robably 4 Unknown | | |
| 20 | law re nas ber 2 sho | Completed | | | | | 24a. Was auto | psy prior to | utopsy findings available completion of cause of | | |
| <u> </u> | n: The ficate l | | 25. Was case referred to medical | | | | 1 □ Yes | | s 2□No | | |
| 5 | lysicia lis certi directo | To Be | examiner? | patient 2 ER/Outpatie | ent 3 DOA Oth | 26. Place of Death ner: 4 Nursing Ho | | o <i>ne)</i> idence 6 ∐Other <i>(Spe</i> | ecify) | | |
| 5 | ling Ph | L:uo | Taractical Salt criding | Injury 28b. Time (| Wor | | 28d. Describe | how injury occurred | | | |
| 200 | Attending Physician: The law or death. rector: After this certificate has by the funeral director, page 2 s | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of determined | f Injury - At home, farm, st | | lYes 2□No | | Street and Number or R | ural Route Number, | | |
| 5 | Ital or irs afte ral Dire | Cert | 4 I Torricate | , etc. (Specify) | | | City or To | | | | |
| : | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | Medical | 29a. Certifier 1 Certifying Physician: To the b (Check only one) 2 Medical Examiner: On the base and manne | is of examination and/or i | | | | | | | |
| 1 | To the within To the compl | Me | 29b. Signature and title of certifier | | 29c. Licens | se number | | 29d. Date signed (Mon | th, Day, Year) | | |
| | | | | | 1)0 | 11367 | | - 4/7/08 | | | |
| - | 5 | | 30. Name and address of person who completed/cause | projectin (Item 23a) (Type | (87) | Green | ne | 9/7/68 | d year | | |
| | Stat | | 31. Date filed (Month, Day, Year) 32. | istrar's Signature | Cooks | | | | | | |
| | Registra | ar | 2Fh n a 5000 35 | Color is the | THE SECOND | | | | | | |

DHMH 17 Rev 1/2001

| EXAMPLE Pages 1 an Department of Heal Department of Heal Important: If item 2 any injury or other 2000. | |
|--|--|
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | |
| 10 | |

| | | | For State Registrar | tate of Maryland | | artment of F <i>rtificate of I</i> | | | iene eg. No. | 008 | 28826 |
|----------------------------|--|------------------|---|--|------------------------------|---|---------------------------------------|----------------------------------|-----------------|-------------------------------|---|
| | | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deat | th | | 3. Time of Death |
| н | Physici /Medic | | SHIRLEY REED | | | | | Month NU4 | Day 29 | Year 200 g | 11:35 AM |
| - de | Examin | | 4a. Facility Name (If not institution, give stree | at and number) | | 4b. City, Town, or | Location of Death | | | inty of Death | |
| - | | | HOW ARD COUNTY GO | ENERAL HOSI | PITAL | | m314 | | | ANG | |
| | Funeral | | 5. Social Security Number 6. Sex 1 | 7. Age (In yrs. In | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day) | Year) | | place (State or Foreign ntry) |
| | Director | | 220-30-3742 | 2 ₹ 5€ | Yrs. | | | 11-05-1 | 951 | Mar | yland |
| | and | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | | 10d. Inside City Limits |
| | Mary -f sh | ţo | MD Howard | E | Elkrido | re . | | | | | 1 ☐ Yes 2 No |
| | r 28a | irec | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen | of What Cou | ntry? |
| | h with | Funeral Director | 8018 Riker Road | | | 2 | 1075 | | 119 | SA | |
| | death | ner | 11 Marital Status 12. V | Vas Decedent Ever in U.S Armed Forces? | 3. 13. V | Vas Decedent of H f Yes, specify Cuba | | pecify Yes or No- | 14. 1 | Race - Ameri Black, White, | |
| 9 | or ite | F. | 1 ☐ Never Married 2 🔀 Married | ∐Yes 2 No Yes, GiveXX | | Yes 2∭XNo | Specify: | Thour, Glo., | | ecify: Wh | |
| 8 | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show disal Examinar must be neithed at | d by | 3 Widowed 4 Divorced | ear or Dates: | | | | | | | |
| 7 | "nat | lete | 15. Decedent's Education (Specify only highest grade controls) | | 16a. Deced | lent's Usual Occup kind of work done o DO NOT use retired | ation <i>furing most of work</i> | ring | 16b. Kina o | f Business/In | dustry |
| 21215-0036 | withii iene. than | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | nemaker | / | | | Own Ho | ome |
| | filed I Hyg other | BeC | 17. Father's Name (First, Middle, Last) | į | | | 18. Mother's Nam | e (First, Middle, I | Maiden Suri | name) | |
| <u>la</u> | Ald be Vents rked tlc ev | To E | Douglas R. Becraft | | | | Shirley | M. Hef | lin | | |
| Maryland | l 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Me | | 19a. Informant's Name/Relationship (Type. I | Print) | 19b. Mailin | g Address (Street | and Number or Ru | ral Route Number | r, City or To | wn, State, Zij | Code) |
| | and ealth m 27 | | Allan Reed, Sr. (Hus | | | Riker Ro | | idge, Ma | | | |
| Ore | Pages 1 ment of H ant: If ite | | 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remo | | | sition (Name of natory or other plac | | | 20c. Location | on - City or To | own, State |
| Baltimore, | t. Pa rtmer rtant: | | 4 □ Donation 5 □ Other (Specify) | Mea | | lge Memor | | 9/05/08 | Elkr | ridge, | MD |
| Bal | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Service Licensee | 4.11 | Ga | . Name and Addres | ıfman Fur | eral Hor | ne at | MMP, | Inc. |
| | | Ge d | 1400001 19 | ns the coised the death | 1/2 | 150 Washii | ngton Bly | d_Elkric | ige, N | 1D 210 | 75 Approximate |
| | | | 23a. Part 1. Enter the disease, or complication shock, of the art failure. List only one call immediate of se (Final | | | | g, odor do odraido | or roophatory arr | | | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | SETIC Due to (or as a consequ | | yk. | | | | | 24 HOURS |
| 1 | Examiner ATIANTING ATI THE SHOTILE AT INC. AND A SHOTILE AT INC. AND A SHOTILE AT INC. | | | | | | | | | | ZWEEKS |
| | Do / = | ner | Sequentially list conditions, if any, soung to hand list cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or se a consequ | | | | | | | |
| | and transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 38760, | ficate be executed physician and s the burial-transit | | resulting in death, East | Due to (or as a consequ | ence or): | | | | | | |
| 387 | ficate phys the | dical | d | | | | | | | | |
| Box (| eath certific attending p for use as | Physician/Me | | f yes, outcome of pregna | | | | | 23d. | Date of deliv | ery |
| Ď | death e atte | icia | in the past 12 months? | I ☐ Live birth 2 ☐ Fetal I ☐ Pregnant at time of de | | Ectopic pregnancy Other (specify) | / | | | Month | Day Year |
| P.O. | uires that the de signed by the a d be detached f | hys | 9 ☐ Unknown | Unknown | | | | | | | |
| s, | es tha | by F | Part II. Other significant conditions contribu | - | - | | | | | | the cause of death? |
| ord | w requires been si should b | ted | CHANNIC MONTH FAI | | | SPIRATURE | | 4 1 1 Ye | es 20XUN | o 3∐Pro | bably 4 ☐ Unknown |
| Division of Vital Records, | e law i has b | Completed | TYPE T MARGETES | M541755 | <u>6</u> | 5 monys | 1617 | 24a. Was a autops | sv l | prior to co | opsy findings available ompletion of cause of |
| ᇤ | t The cate his page | Co | FUNGEMIA | | | | | perform 1 □ Yes | | death? 1 ☐ Yes | 21 /2 No |
| ₹ ₹ | nyslcian: nis certific director, I | Be | 25. Was case referred to medical examiner? | tal· | | Othe | 26. Place of Deal | , | | | |
| 5 | Phys this | P. | ILI res 2Lphilo | 1 ⊠npatient 2 ☐ I | ER/Outpatien 28b. Time of | t 3LJ DOA | 4 LI Nursing He | ome 5 Reside | | | fy) |
| O | ding Phy h. After thi funeral (| tion | 1 Accident 5 ☐ Pending investigation | (Month, Day, Year) | Injury | Work | Yes 2 □ No | Zod. Describe no | ow injury oc | curred | |
| İSİ | Aften ar deat ector: by the | fica | 3 Suicide 6 Could not be 2 | Be. Place of Injury - At ho | me, farm, stre | | | 28f. Location (Si | treet and No | umber or Rur | al Route Number, |
| ă | s afte | Certification: T | 4 Homicide determined | building, etc." (Specify | " | | | City or Town | n, State) | | |
| | To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | edical (| (Check only 2 Medical Examiner; | n: To the best of my know On the basis of examinat | | | | | | | |
| | the the mplet | Medi | | and manner stated. | | 29c. Licenso | · · · · · · · · · · · · · · · · · · · | | | gned (Month, | |
| | 2 ≥ 5 ≤ | | 29b. Signature and title of certifier | my | | | 36574 | 2 | | | 250 8 |
| | 10 | } | 30. Name and address of person who comple | | 23a) /Tvna 5 | | · - / · ¬ | | | -1 | |
| | 10 | | DAVID O. NEPANI | m ms 10° | 724 1 | 177 W P | ALUXUNT | DKWY | Coru | MSIA | ms 21544 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32 Registrar's Signat | ure | | | | | | |
| | Registr | ar | 31. Date filed (Month, Day, Year) SEP 0 9 2008 | lier A | Ano | des . | | | | | |
| DHN | AH 17 Rev 1/20 | 001 | | 7 | | Andrew. | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | 1 - State Of IV Registrar | | artment of H rtificate of E | ealth and Mental Hy Death | Vglene 200 | 8 2882 |
|--|-------------------|--|--|--|---|--|---|
| Physici | ian | Decedent's Name (First, Middle, Last) Henry Dewey Schoer | nfelder, Jr. | | 2. Date of D Month | Day Year | 3. Time of Death |
| /Medic Examir | | 4a. Facility Name (If not institution, give street and number | ·) | 4b. City, Town, or | | 4c. County of Dea | |
| Funeral Director | | 5T. Agnes Hospital 5. Social Security Number 214-20-0465 6. Sex 1 M 2 F | ge (In yrs. last birthday) 82 Yrs. | _ | Hours Min. 8. Date of B (Month, D April | | rthplace (State or Foreign country) ryland |
| /land | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Lo | ecation | 7 | | 10d. Inside City Limits |
| ne Mary 8a-f sh | Director | Maryland Anne Arundel | Linthicum | | | | 1 □Yes 2 No |
| with the | Dir | 10e. Street and Number 515 Southwell Road | | 10f. Zip Code 21090 | n | 10g. Citizen of What C United S | |
| d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Marical Examinational be meitined at | Funeral | 11. Marital Status 12. Was Decedent Armed Forces 1 □ Never Married 2 Married 1 ■ Yes 2 □ | 1 No. | Was Decedent of His If Yes, specify Cubar | spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) | | erican Indian, |
| 0036 | | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | WW II | 1 □Yes 2 ▼No | Specify: | | White |
| 215-i | Completed by | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or | (Give | dent's Usual Occupa kind of work done di DO NOT use retired) | ition uring most of working | 16b. Kind of Business | s/Industry |
| 2 21, Illed with Hygiene ther the | Com | College (1-4or Representative Secondary (0-12) 17. Father's Name (First, Middle, Last) | Self- | -Employed | 18. Mother's Name (First, Middle | Painting C | ontractor |
| /lanc | To Be | Henry Dewey Schoenfelder | renner | · · | | | |
| , Maryland 21215-0036 and 2 should be filed within 72 hours afted the and Mental Hygiene. The marked other than "natural", or the traumatic event, the Madical Exami | | 19a. Informant's Name/Relationship (Type. Print) Loretta F. Schoenfelder / V | | | nnd Number or Rural Route Num Road Linthicu | | |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar in that be notified at once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Bayview (| osition (Name of matory or other place Crematory | 9/9/2008 | 20c. Location - City of Baltimore, | |
| Balt permit Depart Import any Inj once. | | 21. Signature of Funeral Service Licensee | nc. altimore, M | D 21229 | | | |
| Physician //Medical | | 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) | ed the death. Do not entilline. PheRal s a consequence of): | ter the mode of dying | | arrest, | Approximate Interval Between Onset and Death |
| 68760, fifticate be executed by g physician and g physician and gratter transit in a | edical Examiner | Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | s a consequence of): | ARTERY | Disease | | years |
| O. Box 6 the death certification of the attending ched for use as | Physician/Med | | 2 Fetal death 3 | ☐ Ectopic pregnancy ☐ Other (specify) | | 23d. Date of d Month | elivery Day Year |
| cords, P. w requires that s been signed b | þ | Part II. Other significant conditions contributing to death | but not resulting in the u | nderlying cause give | | tobacco use contribute Yes 2 ☐ No 3 ☐ I | to the cause of death? Probably 4 🗌 Unknown |
| I Rec The law ate has b | Completed | | | | per | opsy prior to formed? prior to | autopsy findings available completion of cause of |
| n of Vital ng Physician: T | on: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | ient 2 ER/Outpatier jury 28b. Time of ay, Year) Injury | nt 3 DOA Othe | 4 □ Nursing Home 5 □ Res | | ecify) |
| or Atten or Atten after deat Director: in by the | Certification: To | 2 Accident investigation | njury - At home, farm, str tc. <i>(Specify)</i> | M 1 □ Y | res 2 ☐ No 28f. Location | (Street and Number or I own, State) | Rural Route Number, |
| the Hospital hin 24 hours a the Funeral I | Medical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the bes 2 Medical Examiner: On the basis and manner s | of examination and/or in | h occurred at the tim vestigation, in my op | ne, date and place, and due to the pinion, death occurred at the time | e cause(s) and manner e, date and place, and di | as stated. ue to the cause(s) |
| To the I within 2 To the complet | Me | 29b. Signature and title of dertifier | | 29c. License | | 29d. Date signed (Mor | nth, Day, Year) |
| 51 | | 30 Name and address of person who completed cause of CHASHIDHARAN, DEPT (| OF JURGERY, | | TON AVENUE | | MD 21229 |
| Sta Registr | | 31. Date filed (Month, Day, Year) \$2008 \$2008 | trar's Signature | arte | | | |

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| 70070 | 2 | R | 8 | 2 | C |
|-------|---|---|---|---|---|
|-------|---|---|---|---|---|

| | | | For State of Manyland / Department of Health - State of Manyland / Department of Health - Certificate of Death | | | eg. No. | 20020 |
|-------------------|---|----------------|---|----------------------------------|--|---------------------------------|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Deat Month | Day Year | 3. Time of Death |
| | /Medic | al | Constance Cecilia Szamski | | September | 7, 2008 | 9:13 PM |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 1517 Cocoods lo Dood | | | 4c. County of Deatl | 1 |
| | Funeral | | | timore der 24 Hrs. | 8. Date of Birth | N/A 9. Birtl | nplace (State or Foreign |
| | Director | | 214-22-9693 | rs Min. | 8. Date of Birth (Month, Day 09–08–192 | 7 Maryl | and |
| | yland now | | 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits |
| | a-fsh | ctor | Maryland N/A Baltimore | | | | 1⊠Yes 2□No |
| | or 28 | Director | 10e. Street and Number 10f. Zip Code | | 1 | 0g. Citizen of What Co | ıntry? |
| | ath w | rai | 1517 Greendale Road 2121 | | | U.S.A. | |
| | er de item | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi | : Origin? (Spe ican, Puerto F | cify Yes or No- Rican, etc.) | 14. Race - Amer Black, White | |
| 336 | Irs aft | by F | 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No . If Yes, Give 1 ☐ Yes 2 ☒ No Spec Year or Dates: | cify: | | Specify: W | nite |
| 21215-0036 | 2 hou | ted | 15. Decedent's Education 16a. Decedent's Usual Occupation | | | 16b. Kind of Business/l | |
| 21 | ithin 7 ne. nan "r | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) | nost of Workin | lg | Baltimore (| City |
| 2 | led wi | | 72 Payroll Personnel | | /F: | | |
| Maryland | d be fi | Be (| Andrew Dates C. 11 | | i erirst, midaie, i na Brzozw: | Maiden Surname) | |
| Z | should nd Me mark imati | 2 | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Nur | , | | | in Code) |
| Ma | nd 2 galth a | | Mrs. Joan M. Banick - Sister 1118 Charmuth Road | | | ryland 21093 | ,,, |
| J. | es 1 a of He litem | | 20a. Method of Disposition 20b. Place of Disposition (Name of | | ate | 20c. Location - City or | own, State |
| <u>Ë</u> | Page ment ant: If ury o | | 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 09-13-2 | 2008 | Baltimore, Mar | ryland |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. " "fical Event har" ust be notified at once. | | 21. Signature of Funeral Service Licensee 22. Name and Address of Fa | , | 5305 H | Harford Road | * |
| | <u>v</u> ∪ = # 0 | | Charlef Meins of Leonard J. Ruck, | | | nore, Maryland | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. | n as cardiac o | r respiratory arm | est, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Acute 269 Usbyrushing in death) | 1/2 | eluli | 2 | |
| 4 | Examiner | | Due to (or as a consequence of): | D | | | |
| | | je. | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | |
| * M. | cuted nd ransit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Coronely | all | een d | liveace | |
| , 0° | e exe sian a urial-t | Ë | resulting in death) Last Due to (or as a consequence of): | | | | |
| 68760, | rtificate be executed ng physician and as the burial-transit | Medical | d | | | | |
| | h certifii ending p use as | | IF FEMALE: 23b. Was decedent program: 23c. If yes, outcome of pregnancy | | | | |
| Box | eath cer attendir for use | cian | in the past 12 months? | | | 23d. Date of deli Month | very Day Year |
| O. | that the dended by the detached | Physician/ | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify) | | | | |
| ج. ح. | or Attending Physiclan: The law requires that the death ce birer dear. After this certificate has been signed by the attendi In by the funeral director, page 2 should be detached for use | by PI | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa | art I. | 23e. Did tol | bacco use contribute to | the cause of death? |
| ğ | w require been sign should b | | | | 1 □ Y€ | es 2 □ No 3 □ Pr | obably 4 Unknown |
| မင | law re as be 2 sho | Completed | | | 24a. Was a | n 24b. Were au | topsy findings available ompletion of cause of |
| <u>=</u> | The cate h | Son | | | perform | med? death? | 2 No |
| Vita | iclan: certific ector, | Be | examine: | lace of Death | (Check only on | e) | |
| of Vital Records, | ding Physiclan: The h. After this certificate h funeral director, page | <u>۱.</u> | | | | ence 6 Other (Spec | cify) |
| Division | th. : After | Certification: | 27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury Work? 1 Yes 2 | | od. Describe no | ow injury occurred | |
| /isi | Attendi r death. ector: A by the fu | ifica | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office | | 8f. Location (Si | treet and Number or Ru | ral Route Number, |
| ä | s afte | Sert | 4 ☐ Homicide determined building, etc. '(Specify) | | City or Towi | n, State) | |
| | To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the | | 29a. Certifier (Check only Check only | e and place, a | and due to the c | ause(s) and manner as | stated. |
| | the hin 24 | Medical | one) and manner stated. | | | | |
| | 5 W. 5 | - | 29b. Signature and title of certifier 29c. License number 20 A 2 | 1 U C - | 1 2 | 9d. Date signed (Montl | n, Day, rear) |
| T | | } | 38 Name and address of person, who completed cause of death (Item 23a) (Type, Print) | 18 |) | .1010 | 3 |
| | 8 | | TLA1(MA MOSEM) Swite 312 E, 301 | 180-1 | and I | place 1/2 | EFM1) 2/20- |
| | Sta | te | 31. Date filed (Month, Day, Year) 32. Régistrar's Signature | | | | |

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28829 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Robert P. Sanders September 3, 0538A 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 718 Fifth Avenue Lansdowne 7. Age (In yrs. last birthday) 51 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months **№** M 2□ F Hours Min. 215-70-4351 Dec. Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2X No Baltimore Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 United States 718 Fifth Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates: 1 □Yes 2√□No Specify. Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eagle Express Inc. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden Surname)
Betty O'Grady 17. Father's Name (First, Middle, Last) Paul Edgar Sanders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Fifth Avenue, Lansdowne, MD 21227 Lucille Sanders - Wife . Method of Disposition

↓ □ Burial 2 ☑ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐ Removal from State 9-7-2008 Glen Burnie, MD Ponation 5 Other (Specify) Atlantic Crematory 2. Name and Address of Facility Ambrose Funeral Home, Inc. atule of Funeral Service Licen 1328 SUlphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Arterioscenotic Cardiovas cular disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

> and burial-tran

attending physician

the

for use a

icate has been signicate has been significated by page 2 should by

After this funeral

Hospital or Attending

death.

within 24 hours after death To the Funeral Director: filled in by the

completely

death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show

death

filed within 72 hours after

pe

Pages 1 and 2 should

and Mental Hygiene.

Department of Health a Important: If Item 27 is any injury or other trau

traumatic

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner Physician/Medical ⋧

Completed Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performe 1 ☐Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{\subset}\) Nursing Home 5 \(\text{Residence}\) Residence 6 \(\text{\subset}\) Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

29b. Signature and title

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Registrar

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| | | | State of Maryland / | | | - | _ | |
|---|---|------------------|--|---|---|-----------------------------------|---|--|
| | | • | For State Of Maryland / State Registrar | Certificate of | | | eg. NoO A A A | 20020 |
| E | | | Decedent's Name (First, Middle, Last) | | | 2. Date of Deat | 2000 | 3. Time of Death |
| | Physicia /Medic | | Walter Skinner | | | Sept. 6, | 2008 Year | 0644 A M |
| 2 | Examin | er | 4a. Facility Name (If not institution, give street and number) 709 Harbor Drive | 4b. City, Town, o | or Location of Death | | 4c. County of Dear | |
| 3 - Al | Funeral | | Social Security Number 6. Sex 7. Age (In yrs. last) | birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | a Rid | holace (State or Foreign |
| | Director | | 220 14 4703 ¹ X ^{M 2□ F} 81 | Yrs. Months Days | Hours Min. | June 23, | 1927 Ma | ryland |
| pue | m t | | Usual Residence of Decedent 10a. State 10b. County 10c. City, To | own or Location | | | | 10d. Inside City Limits |
| Many | a-f sho | ţo | Maryland Worcester Ocean | n City | | | | 1 X Yes 2 □ No |
| t t | or 28 se not | Funeral Director | 10e. Street and Number | 10f. Zip Code | | 10 | Og. Citizen of What Co | ountry? |
| t c | is 23a must | eral | 709 Harbor Drive 11. Marital Status 12. Was Decedent Ever in U.S. | 21842 | | pecify Yes or No- | U.S.A. | rican Indian. |
| 0 | ir item | | Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 □ No | 13. Was Decedent of If Yes, specify Cul | | Rican, etc.) | Black, Whit | e, etc. |
| d 21215-0036 filed within 72 hours effer death with the Maryland | ural", c | d by | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | 1 ☐ Yes 2☐ No | | | | White |
| 15-1 | "nati ledica | Completed | (Specify only highest grade completed) | Decedent's Usual Occu (Give kind of work done life. DO NOT use retire | ipation e during most of work ed) | king | 16b. Kind of Business | Industry |
| 212 | giene. | E O | Elementary/Secondary (0-12) College (1-4or 5+) 12 | Checker | | 1 | Waterfront | |
| | _ 0 9 | Be | 17. Father's Name (First, Middle, Last) | | | e (First, Middle, M | | |
| Maryland | marked of | ပ္ | John E. Skinner 19a. Informant's Name/Relationship (Type. Print) 1 | 9b. Mailing Address (Stree | Helen | | urray | Zin Code) |
| Za Za | alth en 27 is er trau | | | 709 Harbor D | | City, M | | - p |
| ore, | of Hearling In the or other | | 20a. Method of Disposition 20b. Place | e of Disposition (Name of etery, crematory or other pla | ace) | Date | 20c. Location - City or | Town, State |
| altimore, | tment tant: Ijury c | | 4□Donation 5 pother (Specifientombment Cedar | HillCemeter | - | | Baltimore, | |
| Bal | Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev | | 21. Signature of Funeral Service Licensee | | hie Hgwy. | | ral Servic Md. 21225 | e P.A. |
| | | | 23a. Pap. Enter the disease or complications that caused the death. I stock, or heart failure. List only one cause on each line. | o not enter the mode of dy | ring, such as cardiac | or respiratory arre | est, | Approximate Interval Between |
| | hysician | | Immediate Cause (Final disease or condition | botterative 1 | ulmona | , Pisce | 42 | Onset and Death |
| | /Medical xaminer | | resulting in death) Due to (or as a consequence) | ce of): | | 1 | | |
| | 1448 | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | ce of): | | | | |
| / Patro | nd transit | Examiner | that initiated events | | | | | |
| 60, | sician and burial-transit | a Ex | resulting in death) Last Due to (or as a consequence | ce of): | | | | |
| | attending physi | edica | d | | | | | |
| · Box | ending | M/us | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de | | cv | | 23d. Date of de | |
| Records, P.O. Box 687 | the att | Physician/Medic | in the past 12 months? 1 Yes 2 No | | - | | Month | Day Year |
| Т. | signed by the a | / Ph | Part II. Other significant conditions contributing to death but not resultin | g in the underlying cause g | iven in Part I. | 23e. Did tol | pacco use contribute to | o the cause of death? |
| Records, | been sign should be | ed by | | | | 1 1 X | es 2∐No 3∐P | robably 4 Unknown |
| 900 | as bee 2 sho | Completed | | | | 24a. Was a | | utopsy findings available completion of cause of |
| | | Соп | | | | perform | ned? death? 2∰No 1 ☐ Yes | · |
| or Vital | certif | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/ | /Outpatient 3 DOA | thor | th (Check only on | | |
| Jor B | h. After this funeral dir | - | 27. Manner of Death 28a. Date of Injury 28 | b. Time of 28c. Injury | | | ence 6 Other (Spe ow injury occurred | ecity) |
| Sior | eath. or: Af | atio | 2 Accident investigation | M 1[| Yes 2□No | | | |
| Division or | after d Direct in by | Certification: | 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify) | , farm, street, factory, office | Э | 28f. Location (St City or Town | reet and Number or R n, State) | ural Route Number, |
| - 4 | hours Ineral | | 29a. Certifier 1 Certifying Physician: To the best of my knowle | | | | | |
| 40.0 | within 24 hours after death. To the Funeral Director: After completely filled in by the funeral | Medical | (Check only 2 Medical Examiner: On the basis of examination and manner stated. | | | | | |
| ļ. | 5 7 W. 1 | _ | 29b. Signature and tile of efficier | | 88)69 | 2 | 9d. Date signed (Mon | |
| , | DXI | | | a) (Type, Print) | NC | F. 1 | | |
| - | 10 | | 30. Name and address of person who completed cause of death (Item 23) | 209 Courted | Holevy | i Gewill | t seems | ME 109144 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) SEP 0 9 2008 32 Registrar's Signature | doneth) | | | | |
| | | | OF A FORD SOCIEDAD YOU | Lake And | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A^{M} 05, Sawyer Marion Kay Sept. 2008 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Crofton Care & Rehabilitation Ctr. Crofton Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **Director** 214-30-1154 74 02-05-1934 Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tra Mudical Examination may be notified as Director 1 ☐ Yes 2 ▼ No MD Anne Arundel Crofton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road Funeral 21114 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or itel 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: δ Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk Giant Food 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Fox Allebach Marion K. Kephart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall S. Sawyer / Son 976 Summerhill Drive Gambrills, Maryland 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Buriał 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arundel Crematory: 09-06-2008 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LYDING disease or condition resulting in death) · /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) the signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform certificate 1 ☐ Yes 2 **X**No 2 **X**No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4) Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Alatural 2 Accident 5 Pending death. 124 hours after death.

1e Funeral Director: A
pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Check only one) within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

State

W

MD

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Sunoh

31. Date led (Month, Day, Year)

Timothy Sova
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06681 **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Medical Examiner 2158 hrs Timothy August 31, 2008 Sova 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Schafers Lane & CSX Railway, BAK 85.90 Mile Marker Baltimore **Baltimore County** 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Under 1 Year Funeral Director Months Days Hours Min 1 XM 2 F 213-80-8509 48 7/8/1960 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 XNo Baltimore Maryland Rosedale Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8505 Contractors Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, or items must be Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygene.
Tant: If item 27 is marked other than "natural", or other traumaite event, the Medical Examiner or other traumaite event, the Medical Examiner. Widowed Divorced f Yes, Give Yea Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Norman E. Sova Muriel Virginia Pindell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 451 Lisa Jones (Sister) Cecilton, Maryland 21913 Baltimore, N permit. Pages 1 and Department of Healt Important: If item 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 9/8 2008 Baltimore City, MD Donation 5 Other Specify: Bayview Crematory 22 Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval een Onset and /Medical Death Multiple blunt force injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical 23a,2/,28a-f, perME, g886 12/31/08 X UNPENDED attending physician for use as the burial **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown this certificate has been signed by the all director, page 2 should be detached fr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes After this certific funeral director, p Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene ٩ 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred subject struck by train 28c. Injury at Work? Natural Yes 2X No To the Funeral Director: completely filled in by the Pending 8/31/2008 Fd 9:47 pm 2 Accident Investigation 28f. Location (Street and Number or Bural Route Number, City or Town, State) BAK 85.90 Mile Marker 28e. Place of Injury - At home, farm, street, factory office building, etc. SCHafers Ln. & CSX Rallroad 3 Could not be Suicide determined (Specify) railroad tracks 4 Homicide ltimore, 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 1, 2008 O F 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

82. Registrar's Signature

UUIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28833 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Travis Lamar Smelley, Jr. 7, 2008 08:00 AM September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Co. 103 Wilson Blvd. SW Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1**▼** M 2□ F 48 Director <u>254-11-8571</u> 31, 1959 Georgia Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 103 Wilson Blvd. SW 21061 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Circit Board Designer Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Travis Lamar Smelley, Sr. Patsy Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Suzanne Shepherd / Wife 103 Wilson Blvd. SW Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept.8, 2008 Glen Burnie, MD 4 Donation 5 Dother (Specify) Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M. Canapp 1 2nd Ave. SW, Glen Burnie, MD 21061 Services; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) IN ER /Medical Due to (or as a consequence of): Examiner METASTHO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ٥ 1 ☐ Yes 2, ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been a page 2 should Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate 1 ☐ Yes 2.2 No To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral D 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

State Registrar

, LEDAKIS 31. Date filed (Month, Day, Year)

LEDAKIS MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA ST. PAUL 32. Registrar's Signature

227

ORIGINAL

D4793

SEPTEMBER 8, 2008

08-06774

James Edward Teat, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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| | | - For State egistrar | | | C | Certifica | ate of | Death_ | | | | | Reg. No. | | | 6 T (D) |
|--|----------------|--|-----------------------|-------------------------|---|--------------------------|---------------------------|---------------------------|-----------------------|-----------------------|-------------|----------------------------------|----------------------|-----------------------------|-----------|--|
| Physicia | | I. Decedent's Name (First, Midd | e,Last) | | | | | | | | | Date of Dea | | Year | | 3. Time of Death 1029 hrs |
| | | James Edward To | eat, | Sr. | | | | | | | | Month Septemb | | | البيا | 1029 1115 |
| | | 4a. Facility Name (if not institution | n, give str | reet and nu | ımber) | | 4 | b. City, Tov | vn, or Lo | ocation of | Death | | | . County of | | |
| | | Anne Arundel Medica | l Cente | r | | | | Annapo | olis | | | | 1 | nne Aru | | 6 |
| Eurorol | - | 5. Social Security Number | 6. Sex | | 7. Age (In y | rs. last birt | thday) | If Under | 1 Year | If Under | 24Hrs. | 8. Date of E | irth (MM/ | DD/YYYY) | 9. Birtl | nplace (State or Foreign Intry) |
| Funeral Director | | 220-66-1862 | . X | 2F | 52 | | Yrs. | Months | Days | Hours | Min. | APR : | 7, 1 | 956 | 000 | MD |
| Director | | | 1 2 M | 2 F | | | 115. | | | <u> </u> | | | | | | |
| | ŀ | Usual Residence of Decedent 10a. State 10b. County | | | 100 | City, Town | or Location | on | | | | | | | | 10d. Inside City Limits |
| , an | | | 1 | - | | • | | | | | | | | | - 1 | 1 Yes 2X No |
| short short | 5 | MD Anne A | runde | <u> </u> | | Glen | Burn | | | | | | 10= Cit | izon of Mh | at Cour | otn/2 |
| faryli 188-f | ect | 10e. Street and Number | 101.004 | | | | | | | | | 0g. Citizen of What Country? USA | | | | |
| the Na or | Director | 530 Glen Ct | | | | | | 2106 | | | | | | | | |
| death with the Maryland or items 23a or 28a-f show any must be notified at once. | ē | 11. Mantal Status | | | cedent Ever | in U.S. | 13. Wa | s Decedent es, specify | of Hisp | anic Drig | in? (Spe | cify Yes or I | V o- | 14. Race White | | can Indian, Black, |
| iem iem ust b | Funeral | 1 Never Married 2 X | Married | Armed F | orces? | No | | | | | i deito i | dodn, oto., | . 4 | | | |
| r. or | 띤 | 3 Widowed 4 Di | | Yes, Give Ye | | | 1 | Yes 2 | No No | specify: | | | | Specify: | Bla | ck |
| irs af ural | ò | 15. Decedent's Education (Sp | ecify only | r Dates: highest gra | ade complete | ed) 16a. | . Deceden | it's Usual O | ccupation | on (Give I | and of wa | ork done | 16b. | Kind of Bu | isiness/ | Industry |
| 2 hou | tec | Elementary/Secondary (0-12 | | | (1-4 or 5+) | | during m | ost of work | ing lite. | DO NOT | use retire | ea) | | | | |
| Simple Contractor | | | | | | | | | Но | me Ir | npro | vement | | | | |
| with with | om | 17. Father's Name (First, Middle | e. Last) | | | | TICLU | 0002 | 1 | 8.Mother | 's Name | (First, Middle | e, Maide | n Surname |) | |
| filed filed the | C | | -,, | | | | | | l ₁ | Me 1 vz | nia | Baile | v | | | |
| 12 d be fenta tarko | o Be | Clayton Teat 19a. Informant's Name/Relation | shin (Tyn | e Print) | ^ | 11 | 9b. Mailin | g Address | (Street | t and Nun | ber or R | ural Route | lumber, | City or Tov | vn, State | e, Zip Code) |
| D 2 shoul and A is n | ř | | | -,,,,, | | 1 | | | | | | ie, M | | | | |
| Matth 2 | | Nancy Teat/Wii | <u>.е</u> | | T | 20b. Place | of Dispos | sition (Nam | e of cen | netery, | JULII | Date | 200 | . Location | - City o | r Town, State |
| re, slau fHe If ite | | 1 Burial 2 Cremati | on 3 | Removal | from State | crema | atory or of | ther place) | | | | | 1 | | | |
| Page ent o | | 4 Donation 5 Other | | | | Metro | Cre | mator | y, I | nc | 9/8, | /08 | Ba | altim | ore, | , <u>MD</u> |
| ultin artm artm oorta | | 21. Signature of Funeral Service | | e o n | | | | - | 4 1 1 | - C.C 117A | | | v1 ar | nd T | nc. | |
| inju Dept. | | 12 18 | | | rodd D | ~ | 129 | 9 Fre | der | ick l | Rd B | of Mar altimo | re. | $\frac{1}{M}$ $\frac{1}{2}$ | 1228 | 3 |
| Physician | | 23a. Part I. Enter the disease | or complic | ations that | caused the | death. Do | not enter | the mode o | f dying, | such as o | ardiac o | r respiratory | arrest, s | hock, or he | eart | Approximate Interval Between Dnset and |
| Medical | | Hood and Neck Injuries | | | | | | | | | | | Death | | | |
| _xaminer | | Immediate Cause (Final disea or condition resulting in death | | | a conseque | | | | | | | | | | | |
| | | | , b | 00 10 (5) 00 | , a 551,554 | | | | | | | _ | | | | |
| | e. | Sequentially list conditions, if any, leading to immediate | D | ue to (or as | s a conseque | ence of): | | | | | | | | | | |
| | Ë | cause. Enter Underlying Cause | c. | | | | | | | | | | | | | |
| W- | Examin | (Disease or injury that initiated events resulting in death) Las | | ue to (or as | s a conseque | ence of): | | | | | | | | | | |
| ransi | ĺ | | d | | | | | | | | | | | | | |
| exectan a land a | ledical | UNPENDED | | AMENDE | D | | | | | | | | | | | |
| Box 68760, e death certificate be executed the attending physician and of for use as the burial - transit | ĕ | IF FEMALE: | | 23c. If ye | s, outcome o | of pregnan | су | | | | | | | 23d. Date | of delive | * |
| 87 tiffice ng pl | M/W | 23b. Was decedent pregnant in | n the | | e birth | | _ | etal death | 3 | Ectop | ic pregna | ancy | ì | Month | | Day Year |
| × 6 h cer tendi | Physicia | past 12 months: | | 4 Pre | egnant at tim | e of death | 5 [| Other (Spe | cify) | | | | - | | | |
| Bo deat | S | 1 Yes 2 No 9 | Unknown | | known | | | | | | A | 220 [| Vid toboo | on use cor | atribute. | to the cause of death? |
| ords, P.O. Box 687 aw requires that the death certific as been signed by the attending p 2 should be detached for use as th | 1 | | ditions | contributin | g to death bu | ut not resul | Iting in the | underlying | g cause | given in F | Part I. | | | | | robably 4 Unknown |
| P.O. es that the general properties of detacles. | <u> </u> | | | | | | | | | | | | Yes 4 | | | |
| Division of Vital Records, rate or Attending Physician: The law requints after death. To a Director: After this certificate has been sind in by the fineral director page 5 should be | Completed by | | | | | | | | | | | | Vas an autopsy | 24t | | autopsy findings available o completion of cause of |
| SOF law re has b | | | | | | | | | | | | 1 | erforme | | death | ? |
| Rec The l | | | | | | | | | | | | | es 2 | No | 1 🗸 | Yes 2 No |
| Vital Reco ysician: The law his certificate has director, page 2 s | Be | | | | | | | | 26.Plac | | | only one) | | | | |
| Vita hysicia this co | - C | | H | ospital: 1 | Inpatient | 2 🗸 EF | R/Outpatie | ent 3 1 | DOA | Other ₄ | Nursi | ng Home | | sidence 6 | | her: |
| Jof V Jing Phy After th | i - | 27. Manner of Death | | 28a. D | ate of Injury onth Day Year 4, 2008 | 28 | Bb. Time o | of Injury | 28c. Inj | ury at Wo | rk? | 28d. Desc Driver a | | injury occ | urred | |
| P P P P P P P P P P P P P P P P P P P | Certification: | 1 Natural 5 F | ending | Sep | 4, 2008 | ' ° | 956 hrs | | 1 | Yes 2 | ∕ No | Divera | G(0 00) | | | |
| Sic Sic Atter dea ectou | 7 | 2 🗸 Accident | nvestigatio | 28a E | Place of Injur | ry - At home | e, farm, st | reet, factor | y, office | building, | etc. | 28f. Local | tion (Stre | et and Nu | mber or | Rural Route Number, City |
| lor after Dir | { | 3 Suicide 6 0 | Could not bletermined | oe | cify) Loca | | | | | | | or To Jennifer | wn, State Road ea | e) ast of Med | dical Pa | arkway, Annapolis, MD |
| Division spital or Attendi hours after death. In teral Director: | ة | 4 Homicide | | (-, | | | | 1 . 1 . 1 | | | nlaes or | | | | | |
| e Ho 124 l e Fu | i dici | 29a. Certifier 1 Certifyin | g Physici | an: To the | best of my k | knowledge, nation and | , death oc /or investi | curred at tr | ie time, nv opinio | oate and on, death | occurred | at the time, | date and | d place, an | d due to | the cause(s) |
| Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin Tro the puneral Director: After this certificate has been signed by the attending the integrated director, name 2 should be detached for use a. | Modical | one) 2 Medical | | and mann | er stated. | naugii ailu | | | | | | | | | | Month, Day, Year) |
| A P P P P |) S | 29b. Signature and title of ce | rtifier | | | | | 29 | | nse numb | er | | - 1 | | - ' | • |
| | | (MOJE | | | | | | | 0.0 | C.M.E. | | | 1 | Septemb | berb, | 2000 |
| 1 | | 30. Name and address of pe | rson who | completed | cause of dea | ath (Item 2 | 3a) | | | | | | | | | |
| 0 | Î | | | | al Exami | | 11 Penr | Street, | Baltin | nore, M | D 212 | 01 | | | | |
| Ψ | | O1 Date Shad (14 of the Control | | | Registrar's | | | - 0- | | | | | | | | |
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| | | | 1 - For state Registrar amend #8 | State of Maryland Per FH g883 9/ | d Peparti Certifi | ent of H Cate of L | lealth and I Death | | giene 1eg. No. 200 | 8 28835 |
|-----------------------|--|-------------------------|--|--|---|--|---|---|---|--|
| | Physici /Medio | | 1. Decedent's Name (First, Middle, La | Turner | | | | 2. Date of Dea Month | Day Yea | A M |
| | Funeral Director | er | 5. Social Security Number 6. S | I firmate over 17. Age (In yrs. In Section 20 F | ast birthday) If Mo | Under 1 Year onths Days | Location of Death C: M If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day | 4c. County of D | Birthplace (State or Foreign Country) 10d. Inside City Limits |
| اء 9 | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I team 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventual must be notified at | Funeral Director | 10e. Street and Number 3018 Fence 11. Marital Status 1 Never Married | 12. Was Decedent Ever in U.S Armed Forces? 1Yes _ 2_No If Yes, Give | 11. Was If Yes | of. Zip Code 216 Decedent of His, specify Cuba | ispanic Origin? (Si in, Mexican, Puerto | | 10g. Citizen of What USA 14. Race - A Black, W | 1 ✓ Yes 2 □ No Country? merican Indian, |
| 121215-0036 | iled within 72 hours a Hygiene. Ther than "natural", c the than "natural", c int. Inc Medical Exa | Completed by | 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest green specified only highest green specif | ducation de completed) College (1-4or 5+) | 16a. Decedent's | of work done of OT use retired | during most of world | W . | Specify: 16b. Kind of Busine CONSH Maiden Surname) | Black ss/Industry cuction |
| جعري e, Maryland 2 | 1 and 2 should be filed w Health and Mental Hygie em 27 Is marked other t ther traumatic event, ID | To Be | 19a. Informant's Name/Relationship (Emma Turn 20a. Method of Disposition | Mer Type. Print) Per/Wife | 19b. Mailing Ad | -enda | Mar and Number or Ru URL | tha | JONES r, City or Town, State MOVE, W | 10 21207 |
| Baltimore, | permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau | | 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 2) Cremation 5 Superior Control of Funeral Service Licer | Removal from State WC | bol av | y or other place Cem The Address The Addr | ekry 9- ess of Fadility VO berty | 9-08 ughn c Rd. Ra | ndalista | un, jud funeral su oun, mozilos |
| Ó | Physician /Medical Examiner | | 23a. Part 1. Enter the divease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) | one cause on each line. | kcyst | e mode of dyin | g, such as card ac | or respiratory ar | rest, | Approximate Interval Between Onset and Death 2 weeks |
| 68760, K | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Lines Unidarying Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | |
| P.O. Box 6 | that the death certificed by the attending podetached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown | death 3 ☐ Ect | opic pregnancy er (s <i>pe</i> ci <i>fy</i>) | у | | 23d. Date of Month | delivery Day Year |
| | w requires that s been signed should be det | þ | Part II. Other significant conditions of | | Iting in the underly | ving cause give | en in Part I. | | | e to the cause of death? Probably 4 ☐ Unknown |
| of Vital Records, | ician: The law certificate has ector, page 2 s | Be Completed | 25. Was case referred to medical | emia i schemic ce | rdiomppy | Hy | 26. Place of Dea | | sy prior med? death 2 ☑ 1 ☐ \ | autopsy findings available to completion of cause of 1? es 2 And |
| _ | a 0 0 | Certification: To B | examiner? 1 Yes 2 No 27. Many r of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined | 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At hor | ER/Outpatient 3 28b. Time of Injury M. M. M. M. M. M. M. M. M. M. M. M. M. M | 28c. Injury Work | er: 4 ☐ Nursing H | ome 5 ☐ Resid 28d. Describe h | ence 6 Other (Some injury occurred | Specify) Rural Route Number, |
| ۵ | To the Hospital or Attendin within 24 hours after death, To the Funeral Director: Aft completely filled in by the fun | Medical Cert | 29a. Certifier 1 Certifying Ph | building, etc. (Specify, yslclan: To the best of my knowniner: On the basis of examinating the e | vledge, death occ | urred at the tin | ne, date and place pinion, death occu | City or Tow , and due to the or rred at the time, o | cause(s) and manne | r as stated. due to the cause(s) |
| | To the within To the comple | Mec | 29b. Signature and title of certifier | and manner stated. | | 29c. License | | | 29d. Date signed (M | onth, Day, Year) |
| | Sta Registr | .~ | 30. Name and address of person who Pomeda Damisse M 31. Date filed (Month, Day, Year) | Singi Hospi | , , , , , , | | | | | 1 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28836 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Mae 12:30PM DA 08 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Fox Meadon Road Baltimore GWYNN If Under 1 Yea If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213.24.089 1 ☐ M 2 🔀 F Director 02/13/1929 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notifled at Baltimore MID 1 ☐ Yes 2 X No GWynn Oak Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be ox Meadow Road 21207 Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Maryland 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella f Health and Menta Item 27 Is marked HuHHarm or Harrison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Road Gwynn Oak MD 21207 verette Fox Meadow Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 Removal from State Owings Mills, MD Forest Garnson 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn Greene Funcia 21. Signature of Funeral Service License Vaush 8728 Liberty Road Kandallstown MD 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cana morily /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of): physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed P Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available Be

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Certification: To Medical

| | | | | | | performed? | death? 1 ☐ Yes 2 € No | | | | |
|---------------------------------------|--------------------------|--|-----------------------------|---|--------------------------------------|---------------------------|--------------------------|--|--|--|--|
| 25. Was case referred to me examiner? | edical | 26. Place of Death (Check only one) | | | | | | | | | |
| 1 Yes & No | Hos | spital: 1 ☐ Inpatient 2 ☐ | ER/Outpatient 3 | ome 5 Residence 6 | ☐Other (Specify) | | | | | | |
| 2 ☐ Accident in | ending vestigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. | Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury | occurred | | | | |
| | ould not be etermined | 28e. Place of injury - At ho building, etc. (Specify | ome, farm, street, fac | 28f. Location (Street and City or Town, State) | l Number or Rural Route Number, | | | | | | |
| 29a. Certifier 🖒 Cer | rtifying Physic | cian: To the best of my know | wledge, death occur | rred at t | the time, date and place | , and due to the cause(s) | and manner as stated. | | | | |

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) JH8VMC 121

ENIENT AVE

Registrar

31. Date filed (Month, Day, 9 2008 SEP

29b. Signature and tifte of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral 28837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** 09^{Month} BARBARA 2:15 AM TATE 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NEW PITTSBURG AVENUE TURNER STATION BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Months Days Hours Director 214-44-1658 63 12-4-1944 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination is the notified at 1 Yes 2 □ No Director MD BALTIMORE TURNER STATION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 732 NEW PITTSBURG AVENUE 21222 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ in any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 □Yes 2 No Specify: BLACK \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ASSEMBLY WORKER WESTERN ELECTRIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ CHAMBERLAIN SAUNDERS CARRIE BELL GLOVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD MAXINE HOWARD/SISTER 639 MAIN ST. <u> 21222</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PK. 9-10-2008 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part t/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) lear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ling physician and e as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s 24a Was an autopsy performed? 1 □ Yes 2 □ No page certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 National Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation thours after death.

uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, or Attending Physician:

State

death.

To the Hospital

Medical

30. Name and address of person who completed cause or death (Item 23a) (Type, Print) MILHAEL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

JHBVML Registrar's Signat

and manner stated

Registrar

29c. License number

EALTER AVE

29d. Date signed (Month, Day, Year)

#a&Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #24b Per Phy G883 9/09/08 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 434 **Physician** HARRY G. THEODORE 5 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL Rosedale Center 8. Date of Birth (Month, Day, Year) AUG. 8,1932 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1**∑** M 2□ F 76 215-30-0115 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Modical Exercitor must be rotified at 1X Yes 2 No BALTIMORE MD N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 USA ROSEMONT AVE 6514 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X Yes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify. á 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL STEELWORKER 8 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGIA HAYES GEORGE THEODORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NOTTINGHAM, MD 21236 4505 NECKER AVE PAULINE WINCHESTER-SISTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY 9/8/08 BALTIMORE, MD 4 Donation 5 Dother (Specify) MILLER-DIPPEL FUNERAL HOME, INC 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final transitional cell carcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit INFECTION certificate be executed wound and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, eritonitis Physician/Medical the r nse IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ∐ Yes 2 XXIo Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A letely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Balto FRANKLIN Square DR md Rivera 9000 0. Juan . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Linda Marie Walton 2131 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 eorge's Prince Chever If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year June 14,1958 Birthplace State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 223–02–1712 **Funeral** 1 □ M 2 🖫 F 50 Months Days Hours Min DC Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Prince George's Completed by Funeral Director Hyattsville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3517 54th. Avenue 20784 USA Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 28 Married Baltimore, Maryland 21215-0036 0 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene.

m 27 is marked other than? Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care Facility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt Miller 011ie Marie Howerton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 3517 54th. Avenue, Hyattsville, MD 20784 Cowanda Hairston / Daughter 20c. Location - City or Town, State Pages 1: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages Department of Important: If its any injury or o once. 1 Surial 2 ☐ Cremation 3 反 Removal from State 9/10/2008 Oak Hill Cemetery Danville, VA 4 ☐ Donation 5 ☐ Other (Specify) Marshall Name and Address of Facility 21. Signature of Funeral Service Lieensee Dorota W. Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Athensel Cardentits disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.

To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊟ Yes 2 No 2. ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2-Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

SEP 0 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

| | | . For | State of Ma | | Depa | artment of H | ealth and I | | | 3 28840 |
|---|----------------|--|--|-------------------------------|--------------------------|--|--|---|---|--|
| | | State Registrar | | | Cer | rtificate of L | Death | Re | g. No. | |
| Physicia | _ | 1. Decedent's Name (First, Middle, La. | Willie | Ja | mes | Wil | son | 2. Date of Death Month | Day Year | 3. Time of Death |
| /Medica | | 4a. Facility Name (If not institution, giv | e street and number) | 4 | ` | 4b. City, Town, or | Location of Death | | 4c. County of Dea | th |
| of . | | Macyland G | eneral + | of. gray | al | Balt | imas , | city | AU | |
| Funeral Director | | 5. Social Security Number 6. S | ex 7. Age | (In yrs. last 78 | birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 5 24 | ^{Year)} 1930 9. Bin | rthplace (State or Foreign ountry) N . C . |
| PL . | | Usual Residence of Decedent | | 10- Ott. T | | | | | | 10d. Inside City Limits |
| arylar show | <u>-</u> | 10a. State 10b. County | | 10c. City, To | | | | | | 1,□Yes 2□No |
| Ba-f | Director | MD | N/A | Balt | imo | | | 10 | g. Citizen of What C | |
| vith th | | 10e. Street and Number | | | | 10f. Zip Code 212 | ΙΩ | 10 | USA | ountry: |
| s 23e | Funeral | 2003 Cecil Aver | 1ue 12. Was Decedent E | Ever in II S | 13 \ | | | inecify Yes or No- | 14. Race - Am | erican Indian. |
| er de item | <u>.</u> | 11. Marital Status | Armed Forces? | | 10.1 | Was Decedent of Hi If Yes, specify Cuba | n, Mexican, Puert | o Rican, etc.) | Black, Whi | |
| If I I I I I I I I I I I I I I I I I I | þ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1√TYes 2 □ N If Yes, Give Year or Dates: | | | 1⊡Yes 2⊠No | Specify: | | Specify: | Black |
| 2 hou | | 15. Decedent's En (Specify only highest gra | ducation | 1 | 6a. Dece | dent's Usual Occup | ation | deina 1 | 16b. Kind of Business | s/Industry |
| 9. 7. 7. 7. 9. 1. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. | ple | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. I | kind of work done of DO NOT use retired | l) | Kiriy | General | Motors |
| d with | Completed | 12th grade | | N/A | _As | sembly J | ine Wo | rker | | |
| al Hy H oth | Be (| 17. Father's Name (First, Middle, Last |) | | | | | me <i>(First, Middle, M</i> M. Sawye | | |
| Ment barkec | 2 | Willie Wilson | | | | | | _ | | |
| 2 sho | | 19a. Informant's Name/Relationship | Type. Print) | 1 | | | | | City or Town, State, | |
| and and Health m 27 her to | | Ernest Wilson | n-Son | OOL Disc | | | | | MD 2121 20c. Location - City o | |
| ges 1 | | 20a. Method of Disposition 1 ← Burial 2 ☐ Cremation 3 ☐ | Removal from State | | | nsition (Name of matory or other place | | - 1 | - | ills, MD |
| allillor rmit. Pages partment of portant: If II y injury or o | | 4 □ Donation 5 □ Other (Special | fy) | Garr | | n Forest | <u>'</u> | | | 1.215/ 115 |
| paritimore, interpretable to the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene. Inportant: If the M21s marked other than "natural; or items 29a or 28a-f show any injury or other traumatic event, the Walcal Examiner must be natified at once. | | 21. Signature of Funeral Service Lice | nsee | | | 1101 E. | | March E | | MD 21202 |
| | | 23a Part 1 Enter the disease or com | unlications that caused | the death. [| | | | | | Approximate Interval Between |
| | 5 1 | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final | | | | | | | , | Interval Between Onset and Death |
| Physician / /Medical | | disease or condition resulting in death) | a CERE | BROW | LASC | ULAR | ACCIDI | ENT | | |
| Examiner | | | Due to (or as | - | | KON | | | | |
| THE PARTY | ler | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as | | | NON | | | | |
| out dansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | c. CONC | ESTL | 115 | HEAAT | FAIL | URF | | |
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| ate be hysici | lical | | d. ATRI | AL | FIR | RILLAT | LON | | <u> </u> | |
| ecords, P.O. BOX 08/ law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the | Physician/Medi | IF FEMALE: | | , | 1000 | | | | | |
| ath cer uttendir or use | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1 Live birth | 2 Fetal de | eath 3 | Ectopic pregnanc | ÿ | | 23d. Date of d Month | elivery Day Year |
| the a | /sic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Pregnant a 9 ☐ Unknown | t time of deal | th 5L | Other (specify) _ | | | | |
| hat th | | Part II. Other significant conditions | contributing to death b | ut not resultir | ng in the u | inderlying cause giv | en in Part I. | 23e. Did tob | pacco use contribute | to the cause of death? |
| Hecords, he law requires t e has been signe ige 2 should be o | l by | 3 | J | | | , , , | | 1 □ Ye | es 2 No 3 | Probably 4 Unknown |
| requires | Completed | | | | | | | 24a. Was a | n 24h Were | autopsy findings available |
| has has ge 2 : | mpl | | - | | | | | autops | y prior to ned? death' | o completion of cause of ? |
| VITAI ician: Th certificate ector, pa | | 25. Was case referred to medical | | | | | OC Diseased De | 1 ☐ Yes 2 ath (Check only on | | es 2 No |
| Sicia s certi | Be c | examiner? | Hospital: | ent 2∏ FE | R/Outpatie | nt 3 DOA Oth | er. | | ence 6 Other (S) | necify) |
| OT J Phy er this | n: To | 27. Manner of Death | 28a. Date of Inju | iry 28 | Bb. Time o | | | | ow injury occurred | |
| nding th. :: Afte | tioi | 1 Natural 5 ☐ Pending 2 Accident investigation | (Month, Da | y, Year) | Injury | | k? Yes 2⊡No | | | |
| VISION r Attending er death. rector: Afte | ific | 3 ☐ Suicide 6 ☐ Could not to determined | 20e. Place of IIII | ury - At home c. (Specify) | e, farm, st | reet, factory, office | | 28f. Location (St City or Town | reet and Number or | Rural Route Number, |
| tal or safte | Certification: | 4 Hornidae | building, et | c. (Opecny) | | | | Jan Say Gr 18 W | , otato) | |
| To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 seconding the completely filled in by the funeral director, page 2 seconding the completely filled in by the funeral director, page 2 seconding the completely filled in by the funeral director, page 2 seconding the completely filled in by the funeral director. | edical (| 29a. Certifier (Check only one) Certifying P | hysician: To the best miner: On the basis of and manner st | of examination | edge, dea n and/or ir | th occurred at the ti nvestigation, in my | me, date and place opinion, death occ | ce, and due to the courred at the time, d | ause(s) and manner late and place, and d | as stated. ue to the cause(s) |
| o the ithin o the | Mec | 29b. Signature and title of certifier | and marrier at | | | 29c. Licens | se number | 2 | 9d. Date signed (Mo | nth, Day, Year) |
| ⊢ ≯ ⊢ ŏ | |) (annixa | | | | 20 | 95QC | | 9-5-0 | 12 |
| , VI | | 30. Name and address of person who | completed cause of c | leath (Item 2 | 3a) (Type, | , Print) | 1200 | | 1 2 | 11: 17 |
| 1011 | | VILOUD | Guduc | , « | no | clo | Don | Jand C | reneral | Hopital |
| Sta | te | 31. Date filed (Month, Day, Year) | All I | ar's Signatur | e | 1 | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Min 1 XXX 2 □ F UNK 213-30-2766 70 Director NOv. 4, 1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturai", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evartinet must be retitled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 √ Yes 2 No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2311 Rosalind Avenue 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Xes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) unk unk ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Sullivan / Guardian 10 N. Calvert Street; Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Zion Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/30/2008 Baltimore, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, MD 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy nerformed' 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this y filled in by the funeral di Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

り

29b. Signature and title of certifier

31. Date filed (Month, Day,

SEP 09

30. Name and address of person who completed cause

Year) () 2008

(Item 23a) (Type, Print)

of death

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

| | | ı | For State Registrar | riease | | | nd / De | epartment of l Dertificate of | Health an | _ | _ | | 28842 | |
|---------------------------------------|--|-------------------------------|--|--------------------------|---------------------------|--------------------------------|------------------|---|---|-----------------------------|-----------------------------|--------------------------------|--|--|
| | | | 1. Decedent's Name (First | Middle, La | st) | | | | | 2. Date of D | eath | | 3. Time of Death | |
| | Physici /Medio | | Irene We | inste | in | | | | | Sept. | 5, 20 | Year 08 | 8:56 A M | |
| | Examir | | 4a. Facility Name (If not in: | stitution, giv | e street and nu | umber) | | 4b. City, Town, o | or Location of D | | | . County of Death | | |
| | | | Stella Mari | s Hos | pice | | | Timon | ium | | Ва | 1timor | ·e | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth 9 | | | | | | | | | | place (State or Foreign ntry) | |
| | Director | | 215-05-4115 | | UM 243 F | 9 | 3 Yr | s. Months Days | Tiodis | Sept. | 21,191 | 4 Mar | y l and | |
| | pur * | | Usual Residence of Deced | | | 100 (| City, Town o | r Location | | | | | IOd Inside City Limite | |
| | sho | ō | | | | | * | | | | | | 10d. Inside City Limits 1X Yes 2 □ No | |
| | the N | ect | MD 10e. Street and Number | N/ | A | B | altim | | | | | | | |
| | with | ä | 6210 Park H | od obt | a A*** | Unit | 002 | 10f. Zip Code | 1 = | | 10g. Citizen | of What Cour | ntry? | |
| | eath | era | 11. Marital Status | ergne | | | | 212 | | 2 (Cassify Van av N | | USA | and lading | |
| E (0 | ter d | 풀 | 1 □ Never Married 2[| Married | Armed Fo | edent Ever in orces? | 0.5. | Was Decedent of I If Yes, specify Cub | an, Mexican, Po | uerto Rican, etc.) | O- 14. F | Race - Americ Black, White, | etc. | |
| . a 036 | urs a | þ | 3₺ Widowed 4□ Di | | If Yes, G Year or D | ive | | 1 □Yes 2 No | Specify: | | Spe | ecify: Whit | e | |
| 8:56 a. 215-0036 | within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show in Medical Evorning must be notified at | Completed by Funeral Director | 15. De | cedent's Ed | lucation de completed) | | 16a. D | ecedent's Usual Occup | oation | | 16b. Kind o | f Business/In | dustry | |
| 21 | thin le. | gu | Elementary/Secondary (| | | 1-4or 5+) | - " | Give kind of work done fe. DO NOT use retire | d) auring most of | working | | | | |
| 21 | ed wi ygier ver th | Š | 12 | | N/ | 'A | H | omemaker | | | | Own Ho | me | |
| 2008 and 2 | be fill tal H d oth even | Be | 17. Father's Name (First, M | | | | | | 18. Mother's I | Name (First, Middle | e, Maiden Surr | name) | | |
| yla | ould Men larke | 은 | Edward Bar | | | | | | M | ary Un | known | | | |
| 3 5, 2008 Maryland 21 | 2 sh h and r is m | | 19a. Informant's Name/Re | | | | | lailing Address (Street | | | | wn, State, Zip | Code) | |
| | 1 and Healt Sm 2 | _ | Howard Bar | tholo | w/Son | 1005 | | 32 E. Pador | | | · · · · · | D 2109 | | |
| SEPTEMBER Baltimore, N | Pages nent of I int: If lite iry or o | | 20a. Method of Disposition 1 X Burial 2 ☐ Crem | ation 3 🗆 | Removal from | State Du | cemetery, | isposition (Name of crematory or other plac Valley L Gardens | ce) Se | pt. 8, | 20c. Locatio | on - City or To | own, State | |
| E # | it. Pa rtmer rtant. njury | | 4 ☐ Donation 5 ☐ Of | her (Specif | V. | Me | noria | L Gardens | <u> </u> | 2008 | Ti | monium | , MD | |
| SE | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Modical Examination must be notified at once. | | 21. Signature of Funer | ce Licer | Michae | 1 J. F | hag1e | 22. Name and Address Lemmon Fur 10 W. Pador | ess of Facility neral Ho nia Road | ome of Du | laney ' | Valley 21093 | , Inc. | |
| | | | 23a. Part 1. Effer the diseashock, or heart failure | ise, or som | ations that | caused the de | ath. Do not | enter the mode of dyi | ng, such as can | diac or respiratory | arrest, | | Approximate Interval Between | |
| - 1 | Physician | | Immediate Cause (Final disease or condition | . List Offiy | | REATIC | CANCE | 'R | | | | | Onset and Death | |
| | /Medical | | resulting in death) | | a. | (or as a conse | | | | | | | | |
| 13/11 | Examiner | | Sequentially list conditions | | b | | | | | | | | | |
| 7 | sit ed | ine | Sequentially list conditions if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury | Į | Due to | (or as a conse | quence of) | | | | | | | |
| V_{\perp} | xecurand and | Examiner | that initiated events resulting in death) Last | | c | (or as a conse | allence of | | | | | | | |
| 760 | eath certificate be executed attending physician and for use as the burial-transit | calE | | - (| | (| 4== | | | | | | | |
| 687 | | | | | d | | | | | | | | | |
| Box | n cert | Ž | IF FEMALE: 23b. Was decedent pregna | nt | 23c. If yes, ou | tcome of preg | nancy | | | | 23d | Date of delive | erv | |
| IN B | death e atte d for | icia | in the past 12 months 1 □Yes 2 No | | 4 🗌 Preg | birth 2 Fe nant at time of | | 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _ | У | | | Month | Day Year | |
| STEJ P.O. | t the by the ache | hys | 9 ☐ Unknown | | 9 🗌 Unkr | nown | | | | | | | | |
| INS S, F | s tha | Z P | Part II. Other significant co | onditions c | ontributing to d | eath but not re | sulting in th | e underlying cause giv | en in Part I. | 23e. Did | tobacco use c | ontribute to th | he cause of death? | |
| IRENE WEINSTEIN Vital Records, P.O. B | The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the | Completed by Physician/Medi | | | | | | | | _ 1 🗆 | Yes 2 □ No | 3 ☐ Prob | oably 4 🙀 Unknown | |
| 田の | e law re has be | bet | | | | | | | | 24a. Was | | b. Were auto | psy findings available | |
| IRENE tal Rec | Physician: The la r this certificate had ral director, page 2 | E I | | | | | _ | | | | prmed? 2) No | prior to condeath? | mpletion of cause of | |
| II ita | slan: ertific ctor. | Be | 25. Was case referred to mexaminer? | edical | | | | | 26. Place of I | Death (Check only | | - I La Tes | 2 🗀 140 | |
| | hyslo his ce direc | 2 | 1 Yes 2 No | ĺ | Hospital: 1 □ | Inpatient 2[| ☐ ER/Outpa | itient 3 DOA Oth | er: 4 🔲 Nursin | g Home 5 ☐ Res | idence 6 📆 | Other (Specif | HOSPICE | |
| 0 4 | e e e | | 27. Manner of Death 1 X Natural 5 □ F | ending | 28a. Date (Mon | of Injury hth, Day, Year) | 28b. Tim Inju | | | 28d. Describe | | | MODITOR | |
| Si O | endli eath. or: A the fu | atic | 2 ☐ Accident i | nvestigation | | | | | Yes 2 □ No | | | | | |
| Division of | fter di | Certification: | | ould not be etermined | 28e. Place | of Injury - At I | nome, farm | street, factory, office | | 28f. Location City or To | Street and Nu wn, State) | mber or Rura | I Route Number, | |
| | pital o | | 29a. Certifier 1 K Ce | rtifulna Dh | velclan: To the | host of my kr | lowledge d | anth annurund at the ti- | | land and discount the | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, p. | Medical | one) 2 Me | dical Exam | ni ner : On the b | pasis of examir ner stated. | nation and/o | eath occurred at the tile or investigation, in my o | ppinion, death o | ccurred at the time | , date and plac | e, and due to | o the cause(s) | |
| | To T | Σ | 29b. Signature and title of o | ertifier | + | 1 | 111 | 29c. Licens | e number | 40 | 29d. Date sig | ned (Month, | Day, Year) | |
| | / | - | 30. Name and address of p | erson who | completed cause | se of death (Ita | m 23a) /t. | ne Print' | 25 / | 10 | 35/17 | en per | 2008 | |
| | 2 | | DR. ERNESTIN | | | | 1 | VALLEY RD. | ТТМОМ | IUM, MD 2 | 1003 | | | |
| | Stat | е | 31. Date filed (Month, Day, | | 732. R | Registrar's Sign | ature 🍃 | | THUM | TOPIS PRO 2 | .1033 | | | |
| | Registra | ar | SEP 0 9 | 2008 | A Coles | w St | Sipo | | | | | | | |
| | | | O may | | 0 | | | | | | | | | |

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State of Manyland / Department of Health and Mental Hydienes of O.O.

| | 1 | For State Registrar | State of Maryland / Do) | epartment of Ho Certificate of L | | | g. No. | 28843 |
|--|------------------|---|---|---|--|--|--|---|
| | _ | Decedent's Name (First, Middle, Last) | | | | Date of Death Month | n Day Year | 3. Time of Death |
| Physici /Medic | | ANA ELIA WHIT | E | | | Septembe | er 3 2008 | 12:08 P ^M |
| Examir | | 4a. Facility Name (If not institution, give st | reet and number) | 4b. City, Town, or | Location of Death | | 4c. County of Deatl | n |
| | A | Laurel Regional H | ospital | Laure | I Killadar 04 Uro | C Data of Diab | Prince Ge | eorge's |
| Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birth | hday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | | nplace (State or Foreign untry) |
| Director | | 077-36-3372 | 69 | 13. | | Dec. 16 | , 1938 Ci | ıba |
| w w | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| laryla sho ed at | 5 | MD Prince Ge | orgo's Lau | ırel | | | | 1 X Yes 2 No |
| the N 28a- | rect | 10e. Street and Number | orge s Bad | 10f. Zip Code | | 1 | 0g. Citizen of What Co | untry? |
| with ga or the g | Ö | 7618 South Arbory | Lane | 207 | 07 | | USA | |
| ns 2% | Funeral Director | | 2. Was Decedent Ever in U.S. | 13. Was Decedent of Hi | | ecify Yes or No- | 14. Race - Ame Black, White | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at onnee. | by Fun | 1 Never Married 2 Married 3 Widowed 4 X Divorced | Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates: | | Specify: | Cuban | Specify: His | |
| 72 hour natural dical Ex | eted t | 15. Decedent's Educ (Specify only highest grade | ntion 16a | Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired | ation furing most of work | | 16b. Kind of Business/ | Industry |
| within jiene. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Case Worker | | | | nity Hospit |
| Hyg other | Be C | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle, I | Maiden Surname) | |
| od 2 should be file Ith and Mental Hy 27 is marked oth r traumatic event | To B | Beningno Rubio | | | Merce | | ueredo | |
| shound M | - | 19a. Informant's Name/Relationship (Typ | e. Print) 19b. | Mailing Address (Street | and Number or Ru | ral Route Number | r, City or Town, State, . | Zip Code) |
| alth a 27 is 27 is ir tra | | Mercedes G. Bailey | | 27 Brooktre | | | | |
| item of Hea | | 20a. Method of Disposition | 20b. Place of cemeter | Disposition (Name of ry, crematory or other place | ce) | Date | 20c. Location - City or | Town, State |
| Page nent c nt: If | | 1 ☐ Buriat 2 XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | West A | Arundel Crem | . 9-6- | -2008 | Odenton, M | D |
| permit. Departir Importa any inju | | 21. Signature of Funeral Service License | ~ (M01103 | 22. Name and Addres | DC | | Funeral Ho | ome, P.A. |
| | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused the death. Do r | not enter the mode of dyir | ng, such as cardiac | or respiratory arr | rest, | Approximate Interval Between |
| Physician | 8 7 | shock or/heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | | clerotic Vas | | | | Onset and Death |
| /Medical | | resulting in death) | Due to (or as a consequence | of): | | | | |
| Examiner | | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence | of): | | | | |
| ed sit | ine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence | 01). | | | | |
| ecut and I-tran | Examiner | that initiated events resulting in death) Last | Due to (or as a consequence | of): | | | | |
| cate be executed physician and sthe burial-transit | 一一 | | | | | | | |
| cate physi | dical | | | | | | | |
| The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as | Physician/Me | IF FEMALE: | 3c. If yes, outcome pf pregnancy | - | | | 23d. Date of de | elivery |
| eath atten | cian | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death | 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _ | у | | Month | Day Year |
| the d | ysic | 1 ☐ Yes 2 🔀 No 9 ☐ Unknown | 9□Unknown | | | | | |
| that the denetation the stacked to | h H | Part II. Other significant conditions co | ntributing to death but not resulting i | n the underlying cause giv | en in Part I. | 23e. Did to | obacco use contribute | to the cause of death? |
| uires sign Id be | d by | Hypertension | | | | 1 🗆 1 | /es 2□No 3⊡xi | Probably 4 □Unknov |
| w requir been si should l | Completed | | | | | 24a. Was | an 24b. Were | autopsy findings availab completion of cause o |
| The lav | Ę | | | | | autor perfo 1□ Yes | rmed? death? | es 2 🖾 No |
| | | 25. Was case referred to medical | | | 26. Place of De | ath (Check only o | | |
| | o Be | avaminer? | Hospital: 1 ☐ Inpatient 2 XER/O | utpatient 3 DOA Ott | ner: 4□ Nursing H | Home 5 ☐ Resid | dence 6 □Other (Sp | ecify) |
| Physer this eral di | 11- | 27. Manner of Death | | Time of 28c. Inju | iry at | 28d. Describe | now injury occurred | |
| th. : After | Certification: | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Tear) | | Yes 2 No | | | |
| I or Attending Physafter death. Director: After this i in by the funeral di | iji. | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of injury - At home, for building, etc. (Specify) | arm, street, factory, office | | 28f. Location (S | Street and Number or a wn, State) | Rural Route Number, |
| al or s afte | Sert | | | • | | | | |
| To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f | Medical (| 29a. Certifier (Check only one) 2 Certifying Phy 2 Medical Exam | sician: To the best of my knowledg iner: On the basis of examination a and manner stated. | ge, death occurred at the t nd/or investigation, in my | ime, date and plac opinion, death occ | e, and due to the curred at the time, | cause(s) and manner date and place, and d | as stated. ue to the cause(s) |
| o the ithin o the | Mec | 29b. Signature and title of certifier | MI | 29c. Licen | se number | | 29d. Date signed (Mo | nth, Day, Year) |
| F≥Fö | | | purt MD. | 2ח | 4283 | | September | 4, 2008 |
| / | | 30. Name and address of person who | ompleted cause of death (Item 23a) | | | | | |
| 15 | | Muhammad Yusuf, M | | | Laurel. | MD 2070 | 7 | |
| | tate | 31. Date filed (Month, Day, Year) | Registrar's Signature | | | 4010 | | |
| | tate | CED 0 9 200 | 8 Merces M | Brake | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 28844 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 45A M ZAB INS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nanor *>a* aro | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) last birthday) 5. Social Security Number 6. Sex Age Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 217-16-160. Yrs Director naryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? morley Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian 11. Marital Status Black, White, etc. 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 Divorced Specify: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vo. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura Foute Number, City or Town, State, Zi, Fode) PASTOR operatine Meluin atonsville, MD. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 11-08 5 Other (Specify) 21. Signa we of Juneral Service Licens 22. Name and Address of Facility march Fit. 21229 the ther the disease, or complications that caused the death. Do not enter the mote of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebro valan /Medical Due to (or as a consequence of): Examiner terrse 1801 VS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. has been signed by the age 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy rmed? 2D No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Volume to the Funeral Director: After To the Funeral Director: After Total of the Funeral Director of the Funeral Fune 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cicepna 12754 WB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beelforway CHEETHA RAJA MD , 4867 Hollins tony 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

28845 State of Maryland / Department of Health and Mental Hygien 2008 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:10 AM Deptember Karl D. Walker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Perry Point
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. VA Maryland Health Care System Ceci 1 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 Q M 2 □ F Yrs Director 44 3, 1964 Wisconsin 395-58-4147 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 ie marked other then "natural", or Items 23a or 28e-1 ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 28s-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland | Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 5378 Smooth Meadow Way, Unit 14 21902 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Army Military 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 Paul Walker Carolyn Irene Minske 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5378 Smooth Meadow Way, Unit 14 ace of Disposition (Name of Date 20) Maryann Z. Walker / wife Columbia, Md 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. 4 □ Ponation S □ Sther (Specify) Metro Crematory 2008 Catonsville, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 21. Signal re of Fun ral Service License 0 421 Crain Hwy. SE; Glen Burnie, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) System Lymphoma **Physician** entral Vervous MKnowr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) physician Physician/Medical the attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No mmunode Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performed? Yes 2 No certificate 1 Yes To the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 No 1 Yes Certification: To 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 5 ☐ Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation of in by the fr 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signatyre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MW) D0032

State Registrar

0

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Sparke

VA Maryland Health Care System, Perry Roint, Maryland

s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State Registrar | State of Maryland / | Department of F Certificate of I | | | giene Reg. No. 2008 | 3 28846 |
|-------------------|--|---------------------|--|--|--|--|-------------------------------------|--|--|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) | Marcellus W. Wat | kins | | 2. Date of Dea Month Septem | Day Year | 3. Time of Death 3:30 A. M |
| and . | /Medic Examin | | 4a. Facility Name (If not institution, give s | | | r Location of Death | рерсеш | 4c. County of Dear | |
| - | | | Charlotte Hall Ve | | 1-1111 | rlotte Hal | | Saint M | |
| | Funeral Director | | 5. Social Security Number 6. Sex 135 | M 2□F 7. Age (In yrs. last bi | rthday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day 11/22/ | r, Year) Co | thplace (State or Foreign ountry) ryland |
| | and | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tow | vn or Location | | | | 10d. Inside City Limits |
| | Marylan I-f show | tor | Maryland Saint M | larys Cha | rlotte Hall | | | | 1 □Yes 2X No |
| | th the | Jirec | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citizen of What Co | ountry? |
| | ath wi | ral | 29449 Charlotte | | | 0622 | 77 N | U.S.A. | adean Indian |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Examinar must be notified at once. | by Funeral Director | 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 2. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates: WW II | 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2¶ No | dispanic Origin? (Spean, Mexican, Puerto Specify: | Rican, etc.) | Black, Whit | |
| 215-0036 | 2 hour | Completed by | 15. Decedent's Educ | ation 16a | a. Decedent's Usual Occup | oation | 200 | 16b. Kind of Business | |
| 215 | ithin 7: ne. nan "n | nple | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | (Give kind of work done of life. DO NOT use retired | | ng | 4 | |
| 121 | Hygier Hygier Iher th | S | 8th 17. Father's Name (First, Middle, Last) | | <u>Disabled Vet</u> | teran 18. Mother's Name | (First, Middle, | N/A Maiden Surname) | |
| Maryland | d be fi ental I ked ot Ic eve | To Be | · | alcolm Watkins | | | e V. Po | | |
| ary | shoul and M s mar | | 19a. Informant's Name/Relationship (Typ | pe. Print) 19 | b. Mailing Address (Street | and Number or Rura | al Route Numbe | er, City or Town, State, | Zip Code) |
| | and 2 lealth m 27 i | | Dorothy Leto / Fr | | 03 Walton Av | | altimor | e, Maryland | |
| lore | iges 1 nt of H : If itel or oth | | 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ R | emoval from State | of Disposition (Name of ery, crematory or other plac | ce) | | , | |
| Baltimore, | artmer artmer ortant Injury | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License | | n Park Cemete | - | , = | Baltimore, | |
| Ba | permi Depar Impor any Ir once. | | Vanna M & | menoush | 4001 Ritch | GOI | | eral Servic Limore, Mar | e, P.A. yland 21225 |
| | | | 23a. Part 1. Enter the disease, or campli- shock, or heart failure. List only on | cations that caused the death. Do | not enter the mode of dyir | ng, such as cardiac | or respiratory ar | rest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | DEBILIT | 4 | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence | of): TA | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence | of): | | | | |
| / | ecuted ind transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | · | | | | | |
| 68760, | ficate be executed physician and s the burial-transit | al Ex | resulting in death) Last | Due to (or as a consequence | e of): | | | | |
| 687 | ificate g phys is the | edical | d | | | | | | |
| Вох | leath certific attending p | M/us | 23b. was decedent pregnant | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea | th 3 ☐ Ectopic pregnand | °V | | 23d. Date of de | |
| O. B | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Pregnant at time of death 9 ☐ Unknown | 5 Other (specify) | | | Month | Day Year |
| σ. | uires that the de signed by the a d be detached f | y Ph | Part II. Other significant conditions con | tributing to death but not resulting | in the underlying cause giv | ven in Part I. | 23e. Did to | obacco use contribute | to the cause of death? |
| ords | w requires been sign should be | ed by | CORONARY | ARTERY DI | SEASE | | 1 🗆 Y | res 2/2 No 3 ☐ F | robably 4 Unknown |
| Records, | law re nas be 2 sho | Completed | | | | | 24a. Was | prior to | autopsy findings available completion of |
| <u>=</u> | hysician: The law his certificate has t I director, page 2 s | Con | | | | | 1 □Yes | rmed? death? 2 No 1 □ Ye | |
| Zi. | sician certif rector | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | ospital: | Oth | 26. Place of Death | | | |
| of | ding Phy: After this funeral di | n: To | 27. Manner of Death | 1 ☐ Inpatient 2 ☐ ER/C 28a. Date of Injury (Month, Day, Year) 28b. | Time of 28c. Injury Wor | | | dence 6 ☐ Other (Sp now injury occurred | есіту) |
| ion | endin sath. or: Aft he fun | atio | 14 Natural 5 Pending 2 Accident investigation | (Ivioriur, Day, rear) | | Yes 2 □No | | | |
| Division of Vital | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, building, etc. (Specify) | farm, street, factory, office | | 28f. Location (5 City or Tox | Street and Number or F vn, State) | Rural Route Number, |
| | spital ours a neral [| | 29a. Certifier | sician: To the best of my knowled | ge, death occurred at the ti | ime, date and place, | and due to the | cause(s) and manner | as stated. |
| | To the Hospital within 24 hours . To the Funeral completely filled | Medical | (Check only 2 ☐ Medical Examinatione) | ner: On the basis of examination a and manner stated. | and/or investigation, in my | opinion, death occur | red at the time, | date and place, and du | ue to the cause(s) |
| | To the vithing compared to the | ž | 29b. Signature and title of certifier | Mb | 29c. Licens | | | 29d. Date signed (Mor | nth, Day, Year) |
| | ~ V | | Pottum les | - MD | 1 | 67788 | | 9/4/. | 1008 |
| | 71 | | 30. Name and address of person who co | | | lotte Hall | Rd. CH | narlotte Ha | 11, MD 20622 |
| | Sta | | 31. Date filed (Month, Day, Year) SFP 0 9 2008 | 32. Registrar's Signature | 1. W. | | | | |
| | Registr | ar | 3EP U 3 4000 | SARAGERIA LA | DB411 | | | | |

| ise Type or Print in Black Indelible ink. Ensure All Copies Are Legible. | |
|--|-------|
| State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 | 28847 |
| Cartificate of Dooth | |

1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Kinion Buel Welch 6. 2008 5:45 A M September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Hospice Center Timonium 8. Date of Birth (Month, Day, Year) July 18,1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☑ M 2 □ F 231 28 5784 83 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla nartment of Heatih and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 10828 Philadelphia Rd. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 DXYes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inspector Aerospace 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gracie Smiley Christopher Columbus Welch ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Lucille Welch (Wife) 10828 Philadelphia Rd. White Marsh, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Garden's 9/9/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Maryland Signature of Funeral Service Licensee W Durkouske 21221 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** TONGUE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Energlands in injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of). P.O. Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ĮQ. Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Nother (Specify)} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Fumber me

a.m.

5:45

2008

6,

SEPTEMBER

KINION WELCH

State Registrar

ERNESTINE WRIGHT 31. Date filed (Month, Day, Year) SEP 0 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) WITHERSPOON 2008 1150 LLLE SETEMBER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) 1 □ M 2 X F 213-28-9464 76 11-28-1931 SC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location X Yes 2 □ No BALTIMORE 10e. Street and Number 10g. Citizen of What Country 10f. Zip-Code 1708 GUILFORD AVENUE 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 Divorced **BLACK** 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 HOUSEKEEPER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES ISRAEL LUCILLE DINGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ELOUISE CORRY/SISTER 5900 PARK HEIGHTS AVE. APT 501 BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PK. 9-11-08 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) YOCARDIAL NFARLTION Due to (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify)

permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If ifem 27 is marked other than "natural" any injury or other traumatte exercise. Physician /Medical **Examiner**

g physician and as the burial-transit

d by the attending detached for use a

ate has been signe page 2 should be

this

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

β

Completed

Be

မ

Funeral

Director

fshow 3a or 28a-f shov be notified at

23a

or items

must

Examiner /Medical Physician/ à Completed Be ၉ Certification:

Medical

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) xaminer? Hospital: 1 Inpatient Other: 2 🗷 No 2 ER/Outpatient 3 □ DOA 4 \square Nursing Home 1 Tyes 5 Residence 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation Injury М 1 Tes 2 No 2 Accident 3 ☐ Suicide

6 Other (Specify) 28d. Describe how injury occurred 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number RES M.D 000 29d. Date signed (Month, Day, Year) SEPTEMBER

600 North Wolfe St, Baltimore, MD, 21287

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMIT

31. Date filed (Month, Day, Year) State SEP 09 2008 Registrar

(check only

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0207 M PATRICIA ANN WARFIELD september 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner wicom icc Sanstrue PENINSULA DEGIONALMENDALCONTE 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Year) Months Davs Hours 1 □ M 2 😾 F 9/11/1934 MARYLAND 213-32-2113 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinations the notified at 1 XYes 2 No Director **GETTYSBURG ADAMS** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 17325 85 PEGRAM ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL BOOK WAREHOUSE 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fil th and Mental F 7 is marked oth Be PATTERSON JAMES R. WARFIELD ETHEL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a ELLEN HARTLE 1237 PINCH VALLEY RD., WESTMINSTER, MD 21158 - SISTER item 27 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 to Department of Important: If it any injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MARY'S CEM. 9/6/08 SILVER RUN, MD 4 Depation 5 ☐ Other (Specify) 21. Sinna myf Lineral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1, ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ubiscase or injury that initiated events Due to (or as a consequence of): Examiner sician and the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 Live birth 2 Fetal death 4 Pregnant at time of death Day in the past 12 months? Month Year 1 ☐ Yes 2 ☐ No the Ö 9 Unknown signed by to d be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 741 MONARU EMBOLISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 45 CV 17 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 24 hours after death. 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ma P0062916 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print) SOUND INVISION SUITE B SHISBURY MI TRANA 64 PERNEZ 32. Registra 's Signatro 31. Date filed (Month, Day, SEP 0 9 2 SEP 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28850 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 2008 20:52 PM 09 Marie Victoria Zamkowski 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bel Air, Maryland Harford Upper Chesapeake Medical CEnter Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Min Days Hours 1 □ M 2 🕱 F 12/10/1913 Maryland 94 213-09-9266 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 ☐ Yes 2X No Baldwin Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6712 Lewis Road 21013 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ki No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown 8 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Grycz John Grudziecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6712 Lewis Road - Baldwin, Maryland 21013 Carol P. Foreman (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 09/13/2008 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee Gil 11750 Belair Road - Kingsville, Maryland assal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner de attending physician and defor use as the burial-transit

Examiner Physician/Medical þ Be Completed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan sartment of Health and Mental Hygiene.

oatmant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Its Mental Examinar must be notified at

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau

After this certificate has been signed by the funeral director, page 2 should be detached Certification: To To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

IF FEMALE 23b. Was decedent pregnant

| 25. | | referred to medic | 3 |
|-----|-----------|-------------------|---|
| | examiner? | | |
| - | | | - |

5 Pending investigation

Date of Injury (Month, Day, Year) 28a. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work?

1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical

0

State Registrar Natural 2 Accident

3 Suicide

4 Homicide

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

D0036487

29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

pper Chesapeake Dr. Bel Air, mo 21014

31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sara Alice Zollicoffe 1:50 PM Dt. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimore altimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖫 F Months Days Hours Min 248.80.868 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantrar must be notified at MD Funeral Director Baltimore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706 Oakley Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Black Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department Elementary/Secondary (0-12) College (1-4or 5+) Specialist 12th anade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Graham L. McFarland I=lla ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Zollicoffer/Husband 2706 Dakley Avenue Baltimore MD Important: If item 27 any injury or other transce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ₽ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memonal Park 09/06/08 Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jaughn C. Greene Funeral 21. Signature of Funeral Service Licensee auxh Kandallstown, MD 2113 Poad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bould perforation. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed the burial-trans metastanz resulting in death) Last Due to (or as a consequence of): use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached fi P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown cate nas been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 1100 2 No 1 ☐ Yes or Attending Physician; filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: # 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DES OC

State Registrar Baltomere, 2401 WBelvedore Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD, Since hospital of

discince Wahannan

31. Date filed (Month, Day, Year)

| | | 1 - State Registrar | State of Mary | • | artment of t rtificate of | | Mental riyg | giene Reg. No. 4 | 2008 | 28852 |
|---|-------------------|--|--|--|---|--------------------|---|---------------------------|---|--|
| Physici | an | 1. Decedent's Name (First, Middle, Last LOUIS J. APPS |) | | | | 2. Date of Dea Month | Day | Year | 3. Time of Death |
| /Medio | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City. Town. | or Location of Dea | AUG | 31 4c. C | 2008 ounty of Death | 9:00 P ^M |
| Exami | lei | Upper Chesapeake | | nter | Be1 | | | | | County |
| Funeral | | 5. Social Security Number 6. Se | 7. Age (In | yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs | | | 9. Birth | place (State or Foreign ntry) imore, MD |
| Director | | 219-01-0495 19 Usual Residence of Decedent | £ w zur j | 90 Yrs. | | | Jan.29, | 1918 | Balt | imore, MD |
| yland now | | 10a. State 10b. County | 100 | c. City, Town or Lo | ocation | | | | 1. | 10d. Inside City Limits |
| e Mar | cto | MD Harford | 1 | Jarret | tsville | 1 | | | | 1 ☑Yes 2 ☐ No |
| th with th | Funeral Director | 10e. Street and Number 3912 Federal Hill | Road | | 10f. Zip Code 210 | 84 | | 10g. Citize US | n of What Cou A | ntry? |
| partitioner, interference of the Inc. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be multiled at once. | þ | 11. Marital Status 1 ☐ Never Married 2√√Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 1 No | | Specify Yes or No- to Rican, etc.) | | . Race - Ameri Black, White, pecify: Wh | |
| 72 hc "natur | Completed | 15. Decedent's Edu (Specify only highest grad | | 16a. Dece | dent's Usual Occu kind of work done DO NOT use retire | 16b. Kind | of Business/In | dustry | | |
| within ene. | dwc | Elementary/Secondary (0-12) | College (1-4or 5+) | 1 | DO NOT use retire rneyman/ | | | Tra | ansfer | & Storage (|
| filed I Hygi other ent, II | BeC | 17. Father's Name (First, Middle, Last) | ırname) | d Beorage e | | | | | | |
| should be tnd Mental marked o | 5 E | John Apps | | | | Annab | ell Dotte | wich | | |
| and 2 sho ealth and n 27 is m | | 19a. Informant's Name/Relationship (7) Laura V. Apps | rpe. Print) | l l | ng Address <i>(Street</i> 2 Federa | | oad, Jar | | | ^{o Code)} MD 21084 |
| Pages 1 a ment of He ant: If item ury or othe | | 20a. Method of Disposition 1, Burial 2 □ Cremation 3 ☑ F 4 □ Donation 5 □ Other (Specify) | Removal from State | Ob. Place of Dispondence Cion Lu | esition (Name of matory or other plate) theran C | ce) Sept | Date 4, | | ition - City or To en Rock | own, State , PA 17327 |
| Deficient Pages Department of Important: If i any Injury or once. | | 21. Signature of Funeral Service Licens | | 22 | 2. Name and Address | ess of Facility (| Geiple Fu Glen Rock | | | |
| Physician /Medical | | 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | ications that caused the ne cause on each line. a. Due to (or as a col | - m | | ng, such as cardia | | rest, | 1752 | Approximate Interval Between Onset and Death |
| Examiner pu ausit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Dué to (or as a eur | гоедистве оту: | | · | | | | |
| rificate be executed by physician and as the burial-transit | - | resulting in death) Last | Due to (or as a co | nsequence of): | | | | | | |
| Attending Physician: The law requires that the death certificate be executed refeath. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 [| ☐ Ectopic pregnand ☐ Other (specify) _ | су | | 23 | d. Date of deliv | ery Day Year |
| quires that n signed b | by | Part II. Other significant conditions con | ntributing to death but no | t resulting in the u | nderlying cause giv | ven in Part I. | 100 | | | he cause of death? |
| he law requir e has been s age 2 should | Completed | | | | | | 24a. Was a autops perfori | sv | 24b. Were auto prior to co death? | opsy findings available ompletion of cause of |
| hysician: The kinis certificate ha | O | 25. Was case referred to medical | | | | 26 Place of De | 1 □Yes ath (Check only on | 2 🖟 No | 1 □Yes | 2 ₩6 |
| nysici | To B | examiner? 1 ☐ Yes 2 ☑ No | lospital: 1 Inpatient | 2 ☑ ER/Outpatier | nt 3 DOA Oth | | dan (onesident only side | | ☐Other (Speci | fv) |
| ding Ph h. After th funeral | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Yea | 28b. Time of Injury | 28c. Inju Wor | ry at | 28d. Describe he | | | 27 |
| al or Attendi after death. I Director: A d in by the fu | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - building, etc. (S | At home, farm, stropecify) | | Yes 2□No | 28f. Location (S. City or Town | treet and I n, State) | Number or Rur | al Route Number, |
| To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by | Medical C | 29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Exami | sician: To the best of my ner: On the basis of exa and manner stated. | y knowledge, death mination and/or in | n occurred at the ti vestigation, in my | me, date and place | e, and due to the durred at the time, o | cause(s) a late and pl | nd manner as a lace, and due t | stated. o the cause(s) |
| To th withir To th comp | Me | 29b. Signature and title of certifier | | | 29c. Licens | se number | 2 | 29d. Date s | signed (Month, | Day, Year) |

10 State

MR# 103689

APPS, LOUIS

SEP 0 9 2008

STEVEN BENTMAN MD 500 UPFER CHESAFEAKE DRIVE BELAIR MD 21014

31. Date filed (Month, Day, Year)

SFP 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

20036487

09/02/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Adkinson William 20, 2008 7345A M /Medical RIGUST 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Doctors Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year Months Days 13573M 2 □ F 577-66-2298 Director 57 Sept. 26,1950 D.C. Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any holyor or other traumatic event, it. "A dieal Exammer must be notified. Director txExtYes 2 □ No Prince Georges Upper Marlboro MD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20772 USA 5302 Shirley Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: **会** Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4dKinson, Communication Clerk Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Issac Adkinson ပ Gladys House 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5302 Shirley Dr. Upper Marlboro, Md. 20772 Bertina M. Adkinson /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 25, 2008 | Suitland, Maryland Washington National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave. N.W. Washington, D.C. 20011 278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ventricular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Fuh curs after death.

Fuh meral Director: After this certificate has been signed by the attending physician and stely filled in by the funneral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No cate has t page 2 s 24a. Was an autopsy Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 □Yes 2 □No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours the Funeral Directory filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only To the within 2 To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Suit 302 (anham, MD. 20106

DHMH 17 Rev 1/2001

Registrar

homas

31. Date filed (Month, Day, Year)

MD

KO

AUG 2 5 2008

8100 Good Luck

Registrar's Signature

08-06329 Pauline Addison Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 28854

| | | - For State | Certificate of Death Reg. No. | | | | | | | | | O = 0 0 | | | | | |
|--|---|---|--|----------------------|------------------------------|---------------|-----------------------|---------------------------|----------|---------------------------------|-----------|----------------------|-----------------|------------------------------|-----------------------------------|--|----------|
| Physicia edical Examin | ın/ | 1. Decedent's Name (First, Middl Pauline | | nn) | ison | | | | 2 | Date of De Month August 1 | 8, 200 | Year)8 | | 3. Time of Death 2237 hrs | | | |
| | | 4a. Facility Name (if not institution Civista Medical Center | | reet and nu | imber) | | 4 | b. City, Tov La Plata | | ocation of | Death. | | - 1 | c. County of D Charles | | | |
| Funeral | | 5. Social Security Number | 6. Sex | | 7. Age (Ir | yrs. last bir | rthday) | If Under | | If Under | | | | l c | | place (State or | |
| Director | | 229-34-0504 | 1M | 2 X F | 8 | 2 | Yrs. | Months | Days | Hours | Min. | July | 14, | 1926 | Cou | _{ntry)} Virgini | .a |
| | t | Usual Residence of Decedent | | | | | | | | | | | | | | 10d. Inside City Lim | nits |
| v any | | 10a. State 10b. County | | | 10 | c. City, Town | | on | | | | | | | - 1 | 1 Yes 2 X | |
| and show | 5 | Maryland Charl | es | | | walu | .011 | 1 | | | | | 10g Ci | tizen of What | Coun | | \dashv |
| Maryl 288- | Directo | 10e. Street and Number | D 1 | | | | | 10f. Zip C | 601 | | | | | g. Citizen of What Country? | | | |
| ith the Maryland 23a or 28a-f show any notified at once. | | 3784 Gardiner | | 0.1W D- | dept Fix | es in II S | 12 1/10 | _ | | anic Origi | n? / Spe | cify Yes or N | | | Americ | can Indian, Black, | |
| ith wir | uneral | 11. Marital Status 1 Never Married 2 N | larried 1 | 2. Was De Armed F | Forces? | | If Y | es, specify | Cuban, | Mexican, | Puerto F | Rican, etc.) | | White, | , etc. | | |
| er des | ш | | vorced If | Yes, Give Yes | 2 X | No | 1 Yes 2 X No specify: | | | | | | | Specify: | whi | te | |
| urs aft turaf | g P | 15. Decedent's Education (Spe | . 0 | r Dates: | | eted) 16a | . Deceden | t's Usual O | ccupatio | on (Give k | ind of we | ork done | 16b | . Kind of Busin | ness/li | ndustry | |
| 21215-0036 Uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", cewent, the Medical Examiner. | Completed | Elementary/Secondary (0-12) | T | College | (1-4 or 5+) | | | ost of worki | ng me. | DONOT | ise reure | su) | | D 0 | | 0 | |
| othin ar tha | 립 | 5 | | | | | Co | ok | 14 | 0.84-45 | Nama | (Circt Middle | Maide | Day Con Surname) | are | Center | |
| 5-0 iled w Hygic d other | | 17. Father's Name (First, Middle | | | | | | | - [' | | | urgi11 | | an Sumanie) | | | ļ |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica | o Be | Farley Thomps 19a. Informant's Name/Relation | on | e Print \ | - | - 11 | 9b. Mailin | a Address | (Street | | | | | City or Town, | State | , Zip Code) | |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once | ř | Peggy Dickers | | | er | 1.15 | | | | | | | | de, MD | | 20746 | _1 |
| ore, MD 21215-003 or 1 and 2 should be filed within or Health and Mental Hygiene If tiern 27 is marked other II ther traumatic event, the Mec | | 20a. Method of Disposition | | | | I | | sition (Name | | | | Date | - 1 | c. Location - C | - | | |
| Baltimore, MD 21215-0036 Department of Health and Mental Hygiene Oppsprunent of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be | | 1 XBurial 2 Crematic | ed Grove Cemetery 09/02/2008 Norton, Virgini | | | | | | | Virginia | | | | | | | |
| Baltimo permit. Page Department (Important: injury or otl | - | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Ir | | | | | | | | | | | ıc | 6633 01d | | | |
| Ba Perm Depy Imp | CC C | Munt | 192 | | 100 | 0153 | A1 | exand: | ria_ | Ferr | y Ro | oad, C | <u>lint</u> | ton, MI | | 20735 | |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calcular or respectively. Between the disease or complications that caused the death. Do not enter the mode of dying, such as calcular or respectively. Between the disease or complications that caused the death. Do not enter the mode of dying, such as calcular or respectively. | | | | | | | | | | | | t | Approximate Inte Between Onset | | |
| /Medical *xaminer | E 7) | | | | | | | | | | | | | Death | | | |
| Administ | | or condition resulting in death) | D | ue to (or as | a conseq | uence of): | | | | | | | | | | | |
| | ᆸ | Sequentially list conditions, if any, leading to immediate | D | ue to (or as | a conseq | uence of): | | | | =1 | | | | | | | |
| | 퍨 | cause. Enter Undenying Caus (Disease or injury that initiated | C | ue to (or as | | | | | | | | | | | | 10 | |
| cuted and transit | Examiner | events resulting in death) Last | | | | | | | | | | | | | | | |
| exe an a | edical | UNPENDED | | AMENDE |) | | | | | | | | | | | | |
| 760, ficate be g physicis the burit | n/Med | IF FEMALE: | | 23c. If ye | s, outcome | of pregnan | | | | | | | | 23d. Date of | | - | |
| ox 687 eath certific attending p | jan/ | 23b. Was decedent pregnant in past 12 months? | tne | 1 Live | | me of death | | etal death other (Spec | 3 | Ectopi | c pregna | nancy Month Day Year | | | | | |
| Box 68 e death certif the attending ed for use as | Physiciar | 1 Yes 2 ✓ No 9 U | nknown | | known | | 3 (| iner (Spec | .ny) _ | | | | | | | | |
| D.O. Be that the de ned by the detached f | | Part II. Other significant cond | itions | contributing | to death | but not resul | Iting in the | underlying | cause 9 | given in Pa | art I. | | | | | the cause of death | - 1 |
| res that the signed by | d by | | | | | | | | | | | | | | | bably 4 Unkno | |
| ords, v requir s been s should | ete | | | | | | | | | | | | utopsy | р | rior to | utopsy findings ava completion of cause | |
| eco ne law te has | Completed | | | | | | | | - | | | | erforme es 2 | | eath? ✔ ` | | No |
| Vital Recysician: The list certificate director, page | ပိ | 25. Was case referred to medi | cal | - | | | | | 26.Place | e of Death | (Check | only one) | | | | | - |
| Vita hysicia this ce | o Be | examiner? 1 ✓ Yes 2 No | Ho | ospital: 1 | Inpatien | t 2 🗸 EF | R/Outpatie | | OA | Other ₄ | | ng Home 5 | | sidence 6 | Oth | er: | |
| n of V ling Phy After th | Ë | 27. Manner of Death 1 ✓ Natural 5 Page 1 | | 28a. Da (Mo | ate of Injur onth, Day,Ye | y 28 ar) | Bb. Time o | f Injury | | ıry at Wor Yes 2 | _ | 28d. Desci | noe now | injury occurr | eu | | |
| ttendi death. | ig | | ending vestigatio | n | | | | fastas | | | | 28f Locati | on (Stre | et and Number | er or F | Rural Route Number | r. City |
| lvis lor A after Direc | 28e. Place of Injury - At home, farm, stree | | | | | | | | | bullarily, e | ;10. | | vn, State | | | | ,, |
| D sspita hours meral y fille | | 4 Homicide | | 1 | | les oudodos | dooth occ | urred at the | time d | late and n | lace an | d due to the | cause(s | s) and manner | as sta | ated. | |
| the Ho in 24 the Fu | Medical | (Check only one) 2 Medical E | xaminer: | On the bas | sis of exam | ination and | or investig | ation, in my | y opinio | n, death o | ccurred | at the time, | date and | d place, and d | ue to | the cause(s) | |
| To t With To 1 | Med | 29b. Signature and title of cert | | and manne | er stated. | | | | | se numbe | | | | | | lonth, Day, Year) | |
| | | | 11 | < N | ω | | | | O.C | .M.E. | | | / | August 19, | 200 | 8 | |
| | | 30. Name and address of pers | | 1 | | eath (Item 23 | 3a) | | | | | | | | | | |
| | | Tasha Greenberg N | | ssistant | Medica | l Examin | er 11 | 1 Penn S | Street, | , Baltim | ore, M | D 21201 | | | | | |
| | State | 31. Date filed (Month, Day, Ye | 2000 | | | 's Signature | Sec. | 8. 0 | | | | | | | | | |
| Regi | stra | SFP 09 | LUUG | AM | Market . | 100 | A STATE OF | | | | _ | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Brown Ulysses 08 2008 7:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital E.R. Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/27/1921 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□ F 86 Months Days Hours Min. Yrs Director Pennsylvania 168-12-2342 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It we Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7005 Copper Sky Court 20772 USA Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1,Efyes 2 DNo If Yes, Give Year or Dates1942-1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Minister Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Brown Ida Mae Ellis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7005 Copper Sky Court, Upper Marlboro, MD 20772 Jettie M. Brown/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It any Injury or c once. 1XXBurial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Floral Hills Cemetery 08/15/2008 Danville, VA 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee 3831 Georgia Ave., NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran signed by the attending physician be detached for use as the burial Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown heen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Was calc referred to medical examiner? certificate 1 ☐ Yes 2 ☑ No 2 🗆 No Division of Vital or Attending Physiclan: nours after death.

neral Director: After this certific
filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Beath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005038 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20777 Marlboro Pike, upper John NILLS 14310 31. Date filed (Month, Day, Registrar's Signature Year) State AUG 25 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Reuben Bowen August 19,2008 Year **Physician** 1238 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Sept. 27 1018 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**√**M 2□ F 212-16-5450 89 Maryland Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **worde** ns 23a or 28a-f eho 1 ☐ Yes 2 No Maryland Calvert Directo Huntingtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1585 Old Plum Point Road 20639 United States Funeral item 27 ie marked other than "natural", or items other traumatic event, the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married I Yes 2 □ No If Yes, Give Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William West Bowen Mary Rebecca Hance 19a. Informant's Name/Relationship (Type, Print)
Minnie M. Bowen -wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, \$1585 Old Plum Point Road Huntingtown, MD 20639 : If item 27 i 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Emmanuel Church Cemetery August 22, 2008 Huntingtown Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA rausch 8325 Mt. Harmony Lane Owings Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician Embolism** Kulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician end for use as the burial-transit law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been signated to page 2 should to 1 Yes 2 No 3 Probably 4 Unknown Cerebro Vascular accident Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2. No of Vital 1 ☐ Yes Be funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number August 19, 2008

DHMH 17 Rev 1/2001

State Registrar

eu) 15+1

100 Huspital Road, Prince Frederick, MD 20678

30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registr s Signature

Hepp

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 1. Deceder's Name (Freit, Modific, Last) 2. Date of Obash Mark 2. Date of Obash 2. D | | | | 1 - State Registrar | | , | Cer | tificate of I | Death | | Reg. No | 2008 | 28857 | | |
|--|----------|--|------------|--|------------------------------------|--------------------------------|---------------|---|--|---|---|---|----------------------------|--|--|
| Ronal of Kay Bevard Framed Ball Langmaid Rd. Group of Market School Sc | Н | Physical at | | 1. Decedent's Name (First, Middle, | Last) | | | | | | eath | | 3. Time of Death | | |
| 84 Facility state of the residence of present of current of the state | 10 | | | Ronald Kay Bevar | rd | | | | | _ | | | 11:30 P ^M | | |
| Second Second Number Project P | | Examir | er | | | | | 4b. City, Town, or | Location of Dea | th | | | | | |
| 172-28-0025 172-28-0025 182 March 192 March | | h, | | | | | | | | | | Worcest | er | | |
| 100 Siles 100 County 100 Ci | | | | 172-28-0025 | 1 0 | | | | | rth ay, <i>Year</i> 1936 | 9. Birthplace (State or Foreign Country) PA | | | | |
| Betty Livingston Bevard Solution Continued Cont | | and w | | | | 10c. City, Town | n or Loc | ation | | | | | 10d Inside City Limits | | |
| Betty Livingston Bevard Solution Continued Cont | | Mary f sho | ō | MD Worces | ster | Nowa | بام | | | | | | | | |
| Betty Livingston Bevard Solution Continued Cont | | the 28a | Je C | | 7001 | Newa | IIN | 10f. Zip Code | | | 10a Ci | itizen of What Cou | | | |
| Betty Livingston Bevard Solution Continued Cont | | 3a ol | | 8412 Langmaid Ro | 1. | | | | | | | • | | | |
| Betty Livingston Bevard Solution Continued Cont | | deatl | ner | | 12. Was Decedent E | ver in U.S. | 13. W | | ispanic Origin? (| Specify Yes or No | 0- | 14. Race - Amer | | | |
| Betty Livingston Bevard Solution Continued Cont | 036 | ours after ral", or Ite Examine | þ | | 1 Yes 2 N | 0 | | | | no Rican, etc.) | | | | | |
| Betty Livingston Bevard Salaz Langmaid Rd., Newark, MD 21841 20 | 2 | 72 ho 'natur dical | etec | 15. Decedent's (Specify only highest of | Education | 16a. | Decede | ent's Usual Occupa | ation | orkina | 16b. k | (ind of Business/I | ndustry | | |
| Betty Livingston Bevard Solution Continued Cont | 2 | vithin ne. han " | d L | Elementary/Secondary (0-12) | | +) | | | | nnig | Ι. | | | | |
| Betty Livingston Bevard Solution Continued Cont | 2 | led w lygiel her tl | | | | | Pou | Itry Ins | | | | | nment | | |
| Betty Livingston Bevard Solution Continued Cont | anc | l be fi ntal F ed ot | Be | | , | | | | | | e, Maider | n Surname) | | | |
| Betty Livingston Bevard Solution Continued Cont | Ĕ | nould d Mei nark | 유 | | | | | | | | | | | | |
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| Physician Physic | ä | Dep Jany | | Kim Mai | Colond | | 1 | | | Burbage | : Fue | enral Hor | ne | | |
| Physician Modelal Examiner Physician Modelal Examiner Physician Cause (Final process) Physician Cause | | | | 23a. Pari1. Enter the disease, or co | emplications that caused t | the death. Do n | ot ente | r the mode of dvin | o. such as cardia | c or respiratory a | rrest | 21011 | Approximate | | |
| Due to (or as a consequence of): Sequential plant Sequential plan | | Physician | | Immediate Cause (Final | | | | | | | irosi, | | Interval Between | | |
| Due to (or as a consequence of): Cause Diesase or injury Cause Diesase or injury resulting in death Last | | | | disease or condition resulting in death) | | | ~ (| Marc | 11011 | | | | | | |
| Due to (or as a consequence of): Cause Diesase or injury Cause Diesase or injury resulting in death Last | | Examiner | | | Due to (olas a | a la o to | n): C | hila | o Lenc | 1000 | | | 11000 | | |
| Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a | | | je l | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a | consequence of | of): | 119/8 | 10113 | 10 1 | | | years | | |
| Section Continue | | outed d ansit | 直 | Cause (Disease or injury that initiated events | | | | 7 | | | | | U | | |
| 24a. Was an alropsy performed? 24b. Were autopsy findings available prior to completion of cause of least of completion of cause of least of completion of cause of least of location (Check only only) 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only only) 27. Mangner of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28d. Describe how injury occurre | Ć, | exec an an rial-tr | Ex | resulting in death) Last | Due to (or as a | consequence o | of): | | | | | | | | |
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| 24a. Was an alropsy performed? 24b. Were autopsy findings available prior to completion of cause of least of completion of cause of least of completion of cause of least of location (Check only only) 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only only) 27. Mangner of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28d. Describe how injury occurre | 7. | that the | | | contributing to death but | not resulting in | the und | terlying cause give | n in Part I | 23a Did t | tobacco i | uca contributa ta | the course of death? | | |
| Andrea Mathias State | oras, | requires een signe rould be | O | gout. | 1-1-1-1 | 1 | | enying cause give | THE PARTS | | | | | | |
| State Stat | | The law te has b age 2 sl | omple | OKNEUMA | TOIC art | MITI. | <u> </u> | | | auto perfo | psy ormed? | prior to co | impletion of cause of | | |
| State Stat | | an: rtifica tor, p | 0 | 25. Was case referred to medical | | | | | 26 Place of De- | | _/>_ | 1 □ Yes | 2 □ No | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | > | nysic lis ce direc | | | Hospital: 1 ☐ Inpatient | t 2 ☐ ER/Out | patient | 3 DOA Othe | | | | 6 ∏Other (See | 6.1 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | 0 | ng Ph fter th neral | | | | 28b. Ti | me of | | at | | | | (1) | | |
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| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | Ĕ | r Att | ≌ | | d Zoe. Place of Injury | y - At home, fari (Specify) | m, stree | et, factory, office | | 28f. Location (| Street an | nd Number or Run | al Route Number, | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | | ital or ral D | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | | Hosp 24 hot Fune stely fit | lical | (Orlean Example 2 Medical Exa | aminer: On the basis of e | examination and | death o | occurred at the timestigation, in my op | e, date and place pinion, death occ | e, and due to the urred at the time, | cause(s date an |) and manner as s d place, and due t | stated. to the cause(s) | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | | o the | Mec | - | and manner state | au. | | | | | | | | | |
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| Andrea Mathias 104 N. Bay St., Snow Hill, MD 21863 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature | | | - | 30. Name and address of parameter | o completed course of the | th (Itam 00=) (** | ive: 5 | | 0010 | (| 0/ | 13/00 | | | |
| State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature | 37 | 112+1 | | | | | | |]. MD 21 | 863 | l | l | | | |
| | 70 71 | | ~ | 31. Date filed (Month, Day, Year) | 32. Pegistrar' | s Signature | | | ., 61 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year -Month 2:30 P.M. **Physician** Glenda Jean Baker 200 PMREY 0008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F West Virginia 220-64-6424 54 July 8, 1954 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, it a Maxical Examiner must be notified at 1 Yes 2 □ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic eventual." U.S.A. 21740 93 Manor Drive Apt A-3 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry Health Care 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Glenn Harris Helman Clara Viola Seilhamer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) C. Sue Redman/Sister 121 Meadowlark Lane, Surray, VA 23883 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Smithsburg Crematory 9/3/2008 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S.Man KSu 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final **Physician** pal disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit 2124221 resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s autopsy certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 □No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 0060396

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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freeth)

Division of Vital Records, P.O. Box 68760, oilal or Attending Physician: The law requires that the death certificate he ave

| | | | | Plea | | | | | delible inl | | | | | | | | | |
|------------|--|---------------------|--|----------------------------------|-------------------|---|----------------------------------|------------------------|--|----------------|--------------------|---|----------------|-----------------------|--|---|--|--|
| | | | For State Registrar | | Sia | te of ivia | aryıan | | artment of rtificate of | | | | Reg. No | 0000 | 3 | 28859 | | |
| | Dhysisi | | 1. Decedent's Name | e (First, Middle | , Last) | | | | | | | 2. Date of De Month | eath Da | ay Yea | . | 3. Time of Death | | |
| - | Physicía /Medic | al | GAI | | SUE | and assemble as | | RATTEN | 4b. City, Town, | or Location | n of Death | 8 | 0149 M | | | | | |
| ľ | Examin | er | 4a. Facility Name (I | MA | CECI | - | ME | DICAL | CENTER | 2 5 | MUS | BURY | 4 | County of De | W | 0 | | |
| | Funeral Director | | 5. Social Security N 215-62-1 | | 6. Sex 1 ☐ M 2 | 7. Ag | e (In yrs. 52 | last birthday) Yrs. | Months Day | | er 24 Hrs. Min. | 8. Date of Bir (Month, Day MAR • 19 | ay, Year | (, Year) Country) | | | | |
| | p | | Usual Residence of | Decedent | | | 10c. Cit | y, Town or Lo | ocation | | | | | | 10d. | Inside City Limits | | |
| | Maryla | tor | MARYLAND | | COMICO | | | PITTSV | | | | | | | | 1 X Yes 2 □ No | | |
| | or 28 | Funeral Director | 10e. Street and Nu | mber | | | | | 10f. Zip Code | | | | 10g. C | Country | ? | | | |
| | sath w | eral | 7418 PIN | E STRE | | s Decedent | Ever in II | S 13 | Was Decedent of | | Origin? (Spe | ecify Yes or No | 2- | USA 14. Race - Ar | nerican | Indian. | | |
| 920 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemplas russ the notified at once. | b | 11. Marital Status 1 X Never Marr 3 □ Widowed | | ed 1 Arn | ned Forces? Yes 2 🕅 es, Give ar or Dates: | No | | Was Decedent of If Yes, specify Cu 1 □Yes 2 🔀 No | | | Rican, etc.) | | Black, Wh | | | | |
| 21215-0036 | 72 hou inatura dical E | Completed | 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busine (Specify only highest grade completed) (Give kind of work done during most of working | | | | | | | | | Kind of Busines | s/Indus | stry | | | | |
| 121 | within iene. than ' | ldmo | Elementary/Seco | | | lege (1-4or 8 | 5+) | | DO NOT use retin | , | | | ļ | DISABLED | | | | |
| | other Jent, I | Be C | 17, Father's Name | (First, Middle, | Last) | | | | | 18. Mo | ther's Name | (First, Middle | , Maide | n Surname) | | | | |
| ylar | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma | To E | JAME | ES | W. | BRATT | EN | SR. | | | EVELYN | | Μ. | POWI | | | | |
| Maryland | d 2 sho th and 7 is m traum | n 1 | 19a. Informant's N | | | nt) | | | ng Address (Stree | | | | | | | | | |
| | s 1 and 2 f Health Item 27 I | | ELLEN PA | | LSIEK | | 20b. F | | osition (Name of matory or other p | | | Date | | Location - City | | | | |
| mo | Pages nent o int: If i | | 1 X Burial 2 4 Donation | | | I from State | | | LE CEMET | | 8/26 | /08 | PIT | TSVILLI | Ξ, Μ | IARYLAND | | |
| Baltimore, | permit. Pages 1 Department of I Important: If ite any injury or of once. | hall of the | | | | | | | | | | | | /ILLE, I | DE. | 19975 | | |
| | Physician /Medical | 80 U | 23a. Part T. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | | l tr | pproximate nterval Between onset and Death | | | |
| | Examiner | | | | | Due to (or as | a conseq | uence of): | | | | | | | | | | |
| | sit sit | iner | Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease of that initiated event | nditions, nmediate erlying | D | Due to (or as | a conseq | uence of): | | | | | | | | - 03 | | |
| o, | e execut an and rial-tran | Examiner | that initiated event resulting in death) | s Last | c | Due to (or as | a conseq | uence of): | | | | | | | | | | |
| 68760, | cate be physici the bu | dical | | | d | | | | | | | | | | - | | | |
| P.O. Box 6 | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit | by Physician/Medica | IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr | months? □No | 1 É | res, outcome Live birth Pregnant a Unknown | 2 Feta | al death 3 | □ Ectopic pregna □ Other <i>(sp</i> ec <i>ify)</i> | | | | | 23d. Date of o | | ay Year | | |
| | uires that the de signed by the a Id be detached t | d by Ph | Part II. Other signi | ficant conditi | ons contribution | ng to death t | out not res | ulting in the u | underlying cause | given in Pa | rt I. | | | | | cause of death? | | |
| Records, | To the Hospital or Attending Physician: The law requii within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should | Completed | | | HTW | | | | | | | 24a. Was auto perf 1 □ Yes | opsy ormed? | prior death | to comp | y findings available bletion of cause of | | |
| of Vital | clan: 'ertifica | Bec | 25. Was case refe examiner? | rred to medica | | | | | | | ace of Deat | h (Check only | | | | | | |
| of V | Physic this c | | 1 ☐ Yes 2 🔀 | | Hospita | 1 Derinpati | | ER/Outpatie | ent 3 🗆 DOA | | | ome 5 Res | - | 6 □Other (S | pecify) | | | |
| O | Attending or death. ector: After by the funer | tion | 1 Maillier of Dea 1 Matural 2 ☐ Accident | 5 ☐ Pendir investi | | t. Date of Inj (Month, Da | ay, Year) | Injury | l w | ork? ∐Yes 2 | 1 | 200. Describe | now m | ary occurred | | | | |
| Division | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification: To | 3 ☐ Suicide 4 ☐ Homicide | 6 □Could detern | | . Place of In building, e | jury - At h tc. <i>(Speci</i> | ome, farm, si fy) | treet, factory, offic | е | | 28f. Location City or To | (Street a | and Number or ate) | Rural F | Route Number, | | |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | Medical (| 29a, Certifier (Check only one) | | Examiner: O | | of examin | | nth occurred at the investigation, in m | | | | e, date a | and place, and o | due to t | he cause(s) | | |
| | | M | 29b. Signature and | uttley of Certifie | 6 | | | | | rnse numb | | | | Date signed (Mo | | ay, Year) | | |
| | 12 | | 30. Name and add | ress of person | • | ed cause of | death (Ite | m 23a) (Type | , Print) | S. | 1 | | A | MA | 21 | PA I | | |
| | Sta | ate | 31. Date filed (Mo. | | 036 K7 | 32. Regist | rar's Sign | ature | EROLL | J' | | KISOU | <u> </u> | 1114 | 410 | | | |
| | Regist | rar | | AUG 2 | 2008 | Alex | us. | BA | ecou - | | | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1846 Kose Badger 2008 Annie AUgus /Medical 4a. Facility Name (If not institution, give street and humber) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSpital Dorche Genero ambrida If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Yrs Director 215-20-2502 82 December 6, 1925 Virgínia Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show if than "natural", or items 23a or 28a-f shouther Medical Examinant by notified at Director 1 Yes 2 □ No Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Maces Lane Funeral 21613 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: Specify: Black 3 Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Seafood Worker Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ပ Jessie L. Badger, Sr. Madge C. Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once. 27 Joyce B. Opher / Daughter 900 Maces Lane Cambridge, Maryland 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 30 08 Cambridge, Maryland Bethel Cemetary 21. Signature of Funeral Service Licepsee 22. Name and Address of Facility Boardley Funeral Home Daar Cambridge, Maryland 21613 812 Hubbard Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between HOUD Immediate Cause (Final **Physician** Intestina disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hours E aquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): law requires that the death certificate be executed Exami attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 No 2 **N**O 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 K Inpatient this Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death P Hospital or Attending Pl 24 hours after death. Funeral Director: After t 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of Aertifier 29d. Date signed (Month, Day, Year) August 22, 2008

State Registrar 31. Date filed (Month

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Brambl

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istrar's Signature

cambridge

ot.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:40 AM Patricia Johnson Clifford 2008 August 18. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hill Haven Nursing Center Prince Georges Adelphi If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛣 F Director 182-56-0015 84 March 20, 1924 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XIYes 2 No Directo MD Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 3210 Powder Mill Road U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify ģ 3 Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed nent of Health and Mental Hygirint: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၟႄ Charles Spurgeon Johnson, Sr. Marie Antoinette Burgette 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Clifford McDaniel 7706 Leeds Manor Court Fairfax Station, VA 22039 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Gate of Heaven 8/27/2008 Silver Spring, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee, 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division or Vital | 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 Tyes Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of eartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 avaKoli Nader 31. Date filed (Month, Day, 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | State of Marylan | | tificate of L | | | Reg. No. 2 | 308 | 288 | 62 |
|--------------------------------|---|------------------|---|--|--------------------------|---|--|------------------------------|-------------------------------|-------------------|--|--------------------|
| | | | 1. Decedent's Name (First, Middle, Last) | | | | | Date of Dea Month | | Year | 3. Time of De | |
| | Physicia /Medic | | Alicia Cordova | | | | | August | 25 2 | 800 | 14:48 | М |
| - | Examin | | 4a. Facility Name (If not institution, give sa | treet and number) | | | Location of Death | | | ity of Death | 0 | |
| -/ | | | 21917 Academy Lane | | | Hagerst | | | | | County | |
| | Funeral | | 5. Social Security Number 6. Sex | M 2 X F 7. Age (In yrs. | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | h y, Year) | 9. Birthp | place <i>(State or F</i> ntry) alvador | oreign |
| | Director | | 565-49-3173 | M 2M 82 | Yrs. | | | June 20 |),1926 | E1 Sa | alvador | |
| | nud w | } | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town or Loc | eation | | | | 1 | 10d. Inside City | Limits |
| | sho | 5 | | | | | | | | | 1 XYes 2 | □No |
| | he M | ect | Delaware Kent 10e. Street and Number | טע | ver | 10f. Zip Code | | | 10g. Citizen o | of What Cour | ntry? | - |
| | a or | Funeral Director | | | | | | | U.S.A | | | |
| | s 23 | era | 1289 Walker Rd. | 2. Was Decedent Ever in U | S 13 V | 19904 | isnanic Origin? (Sp | ecify Yes or No | | ace - Americ | can Indian, | |
| | item item | P. | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 X No | 1 | | ispanic Origin? (Sp an, Mexican, Puerto | Rican, etc.) | В | lack, White, | etc. | |
| 38 | irs af | | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 | □Yes 2 No | Specify: | | Spe | oify: | | |
| ŏ | be filed within 72 hours after death with the Maryland ital Hyglene. 3d other than "natural", or items 23a or 28a-f show event, the Modral Event har must be neithed at | Completed by | 15. Decedent's Educ | ation (1945) | 16a. Deced | lent's Usual Occup | ation during most of work | ina | 16b. Kind of | Business/In | ndustry | |
| 218 | within 7, iene. | ple | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | `life. L | OO NOT use retired | d) | my | 37 | | | |
| 7 | d with | No. | 9 | | Nurse | s Aid | | | | ing Ho | те | |
| pu | be filed ntal Hygi od other event, I | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam Antonia | | | ame) | | |
| yla | hould be id Mental marked c matic eve | ဂ္ | Rafael Alvarez | | | | | | | | | |
| ar | ar ar | | 19a. Informant's Name/Relationship (Type | | | | and Number or Ru Lance, Ha | | | | | |
| 2 | 1 and 2 Health em 27 other tr | | Vladimir A. Corea-s | | | | | Date | 20c. Locatio | | | |
| ore | t of H If itel | | 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Re | emoval from State | cemetery, cren | sition (Name of natory or other plac | | | | | | |
| Ë | Pag tmen tant: fury | | 4 ☐ Donation 5 ☐ Other (Specify) | Smi | | g Cremato | | | | | Mary1a | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 Department of H Important: If Ite any Injury or ot once. | | 21. Signature of Funeral Service License | • 7 | 22 | . Name and Addre | ss of Facility Do | uglas A | . Fiery | / Fune | ral Hom | e 2 |
| | 20 = # 0 | | / Muchany. | Tury | | | | | | JOWII 9 | | |
| | | 1 | 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on | e cause on each line. | th. Do not ent | er the mode of dylr | ng, such as cardiac | or respiratory a | rrest, | | Approximate Interval Betwee Onset and De | en eath |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | arcu | ner | va d | 100 | JCAC | 4 | | 14cors | |
| 4 | /Medical Examiner | | resulting in deathy | Due to (or as a consec | quence of): | | 0 | | | | | |
| | | 7 | Sequentially list conditions, b | Due to for se a cunsus | Lience of it | | | | | | | |
| | ned nsit | Examiner | Sequentially list conditions, if any, leading to innier date cause. Enter Underlying Cause (Disease or injury that initiated events | (0.00 | | | | | | | | |
| | execu al-tra | Xai | that initiated events resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | |
| 68760, | The law requires that the death certificate be executed ate has been signed by the attending physician and oage 2 should be detached for use as the burial-transit | Sal | L d | | | | | | | | | |
| 89 | rtificat ng phy as the | edical | | | | | | | | | | |
| Box | eath certifi attending for use as | 2 | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet | ancy | Ectopic pregnanc | 216 | | 23d. | Date of deliv | | |
| | death e atte d for | icia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4 Pregnant at time of | | Other (specify) | ,y | | | Month | Day Ye | ear |
| P.0 | that the dened by the detached | Physician/N | 9 Unknown | 9 Unknown | | | | | | | | |
| | ires tha signed the def | | Part II. Other significant conditions con | tributing to death but not res | sulting in the u | nderlying cause giv | en in Part I. | | | | the cause of de | |
| ğ | w require been si should b | 9 | Herry C | nellitui | | | | 1 🗆 | Yes 2 | | obably 4 ☐ Ur | IKNOWN |
| of Vital Records, | e law re has be je 2 sho | Completed by | | | | | | 24a. Was | psv | prior to c | topsy findings a completion of ca | vailable use of |
| æ | The la | ĕ | | | | | | perf 1 □ Yes | ormed? 2 □ No | death? 1 ☐ Yes | 2 □ No | |
| ita | siclan: The certificate rector, pag | Be (| 25. Was case referred to medical examiner? | | | | 26. Place of Dea | th (Check only | one) | | ONS H | und |
| Į (| hy lai lai | 2 | 1 ☐ Yes 2 ☑ No | lospital: 1 Inpatient 2 | | | 4 LI Nursing H | ome 5 ☐ Res | | | cify) | |
| | ding Ph h. After th funeral | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Year) | 28b. Time o Injury | Wor | | 28d. Describe | how injury oc | curred | | |
| sio | tendi eath. or: A | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | |]Yes 2□No | not ttion | (Ottd-t) | | und Dauta Numb | |
| Division | or At fiter d direct in by | Certification: | 4 ☐ Homicide determined | 28e. Place of Injury - At Injury building, etc. (Spec | nome, tarm, sti vify) | еет, тастогу, опісе | | City or To | (Street and INI wn, State) | imper or nu | ıral Route Numb | er, |
| | pital ours a seral C | | 29a. Certifier 1 Certifying Phys | sician: To the best of my kr | nowledne deal | h occurred at the t | ime date and place | and due to th | e cause(s) an | d manner as | s stated. | |
| | Hos 24 ho Fun Fun | Medical | (Check only 2 Medical Exami | ner: On the basis of examir and manner stated. | nation and/or in | vestigation, in my | opinion, death occu | irred at the time | , date and pla | ce, and due | to the cause(s) | |
| | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera | Mec | 29b. Signature and title of certifier | 7 | | 29c. Licens | se number | | 29d. Date si | gned (Month | h, Day, Year) | |
| | FSFÖ | | And wall | 1/1 1 | 2 | 10 | 22/07 | | 1110 | 414 7 | 27 71 | W4. |
| | | | 30. Nome and address of person who co | ompleted cause of death (Ite | m 23a) (Tvpe. | Print) | 500 | A 1 : 2 | | - 4[- | | , 0 |
| 0 | 54-4 | | | II W/ 111 | NW | clied | Canon! | 20/Je | gersto | W.V. | 27, 21 mn | 6174 |
| | Sta | ate | 31. Date filed (Month, Day, Year) | 32. Raistrar's Sign | nature | Lands 1 | 1 | | J | | | |
| | Regist | | AUG 2 8 20 | 08 | 15 pm | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 08-06391 2008 28863 Richard Lawrence Cook

| | R | - For State Certifica | ite or | Death | | Reg. | No. | 3. Time of Death | |
|--|----------------|--|----------------------|--------------------------------------|---------------------------------|---------------------|--|---|--|
| Physician ledical Examine | er | Richard Lawrence Cook Month Day Year August 21, 2008 0747 hrs | | | | | | | |
| | 4 | 4a. Facility Name (if not institution, give street and number) 7604 Coastal Hwy | 4 | 4b. City, Town, or Loc Ocean City | cation of Death | | 4c. County of Dea Worcester | th | |
| Funeral | 5 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth | nday) | | If Under 24Hrs. | 8. Date of Birth(| MM/DD/YYYY) 9. B | ian | |
| Director | ł | 578 48 1726 1XM 2F 71 | Yrs | Months Days | Hours Min. | March 3. | | country) PA | |
| any | _ | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | or Locat | ion | | | | 10d. Inside City Limits | |
| * . | Ĕμ | laryland Worcester Ocean (| City | | | | | 1 X Yes 2 No | |
| th the Maryland 23a or 28a-f show notified at once | Ø | 10e. Street and Number | | 10f. Zip Code | | | . Citizen of What Co | untry? | |
| ith the 23a or notifie | | #6 143rd St. Unit 101 11. Marital Status 12. Was Decedent Ever in U.S. | 13. Wa | 21842 as Decedent of Hispan | nic Origin? (Spe | | J. S. A. 14. Race - Am- | erican Indian, Black, | |
| leath w | ሕ ! | 1 Never Married 2 Married Armed Forces? 1 X Yes 2 No | If Y | es, specify Cuban, M | Mexican, Puerto I | Rican, etc.) | White, etc. | 10 | |
| hours after c'hatural", ol | ξ. | Widowed 4 NDivorced If Yes, Give Year or Dates: | | Yes 2 X No s | | ork done I1 | Specify: Wh | | |
| 2 hour | ed - | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | during m | nost of working life. Di | O NOT use retir | | | 1 | |
| 5-0036 iled within 72 Hygiene. I other than 'the Medical | Completed | | evel | oper | Mathar's Namo | (First, Middle, Ma | Real Esta | te Building | |
| 21215-00 uld be filed wit Mental Hygien marked other c event, the Mi | မှု မြ | 17. Father's Name (First, Middle, Last) Richard Cook | | | Notice Ba | | iden damane) | | |
| | 핟 | 19a. Informant's Name/Relationship (Type, Print) | | g Address (Street a | ind Number or R | ural Route Numb | | | |
| altimore, MD Z rmit. Pages I and 2 shou spartment of Health and N portant: If item 27 is n jury or other traumant. | - 1- | 20a. Method of Disposition 20b. Place | of Dispos | sition (Name of ceme | Ur. Ki | Date Devi | H1 S | NC 27948 or Town, State | |
| ages 1. nt of H | | Cape H | tory or of lenle | _{ther place)} open Crema | atory8/2 | 3/08 F | rankford | , DE | |
| Baltimo permit. Page Department o Important: injury or oth | t | 4 Donation 5 Other Specify: 21. Son ture of 5 peal Service Liceptee | 22. [| Name and Address of | f Facility | 108 M. | Illiam St. | | |
| | 1 | 23d. Part I. Enter tile disease, or complications that caused the death. Do n | | rbage Fune | | | | Approximate Interval | |
| Physician /Medical | | failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries | | | | | | Between Onset and Death | |
| xaminer | | or condition resulting in death) Due to (or as a consequence of): | | | | | | | |
| | <u></u> | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | |
| | Examine | Couse E ter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | - | | |
| ficate be executed g physician and the burial - transit | | d. | | | | <u> </u> | | | |
| 50, nte be ex nysiciar e burial | j j | UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy | | | | | 23d. Date of deliv | very | |
| 30x 687(death certifica e attending pl | | 23b. Was decedent pregnant in the past 12 months? | 2 🔃 F | etal death 3 | Ectopic pregna | псу | Month | Day Year | |
| Box death the atter | nysic | 1 Yes 2 No 9 Unknown 9 Unknown | | | | | | 4.10 | |
| ires that the d signed by the | اھ | Part II. Other significant conditions contributing to death but not resulting | ng in the | underlying cause giv | en in Part I. | | | to the cause of death? Probably 4 Unknown | |
| ords, I | eted | | | | | 24a. Was a | | autopsy findings available to completion of cause of | |
| ecor he law 1 ite has b | Completed | | | | | perform | ned? death | 1? | |
| Vital Rec ysiciau: The his certificate director, page | Bec | 25. Was case referred to medical examiner? | | | of Death (Check Other Nursin | | | | |
| f Vit | 유 | 1 V Yes 2 No Inpatient 2 ER/C | Outpatier Time of | | | 28d. Describe h | Residence 6 🗹 O | | |
| on of \ ending Physath. or: After the funeral | ţi | (Month Day Year) | 10 hrs | 1 Ye | es 2 🗸 No | Subject belie | ved to jump fro | om building | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Certification: | 3 Suicide 6 Could not be determined (Specific) Legal Street | farm, str | eet, factory, office bu | ilding, etc. | or Town, St | | Rural Route Number, City | |
| Hospita 14 hours Funera | S | 29a. Certifier 1 Certifying Physician: To the best of my knowledge di | eath occ | urred at the time, date | e and place, and | due to the cause | e(s) and manner as | stated. | |
| To the Hos within 24 h To the Fur completely | Medical | one) 2 Medical Examiner: On the basis of examination and/or and manner stated. | investig | ation, in my opinion, | death occurred | at the time, date a | and place, and due to 29d. Date signed | o the cause(s) | |
| | Σ | 29b. Signature and title of certifier | | 29c. License O.C.M | 01 | OME | August 22, 20 | | |
| | | 30. Name and address of person who completed gause of death (Item 23a) | 1 | | | | | | |
| BAIOTI | | Theodore M. King, Jr., MD. Assistant Medical Exar | | 111 Penn Stre | eet, Baltimor | e, MD 21201 | | | |
| Sta Regist | ate rar | 11111 7 5 71118 1 Ma M | 1 | books | | | | | |
| DHMH 17 Rev 1/20 | 001 | 0 | RIGIN. | AL | | | | | |

State of Maryland / Department of Health and Mental Hygiene20081 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2103 Orighino CARRAVONE 3 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Tonalball TOLING MAY DAD

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
(Month, Day, Micaules. (o-ter PENINIVA Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🂢 F Yrs. 059-34-4600 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Worcester Ocean Pines 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 107 Seafarer Lane 21811 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11, Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 ie marked other then College (1-4or 5+) Oil Company Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sylvia Kutcher David Egort 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George W. Carravone /husband 107 Seafarer Lane, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of the important: if ite eny injury or of 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 8/25/2008 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death 23a. Pant. Immediate Cause (Final disease or condition resulting in death) ADKW (OrCINOMA METATIOTIC Physician /Medical Due to (or as a consequence of): Examiner (OKTINOWA) UTERINE Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit or Attending Physician: The faw requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ₺No 3 Probably 4 □Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 19 No 1 ☐ Yes 2 ☐ No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 fnpatient 2 ER/Outpatient 3□ DOA Certification: To After thi 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Webs H. M olderland רבזרגס 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0. Box 2018 OlicharD CHLOTTMAN Salisbury 31. Date filed (Month, Day, Year) AUG 2 6 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy E. Chaney 19 6:30 P M August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Westminster Carroll County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 √ F Director 215-09-8318 94 9/21/1913 MD. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, Ite Iva fical Evants continue to rediffed at any Injury or other traumatic event, Ite Iva fical Evants continue to rediffed at any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director Md. Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Marks Way, 21158 USA 205 St. Apt. 222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 No Specify white Specify: 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Bookkeeper Hess Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Charles Osborn Beulah E. Peregoy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles P. Chaney, son 519 Dellview Drive, Finksburg, Md. 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/23/2008 Pleasant Grove Cem. Reisterstown, Md. 21. Signature, of Juneral Service Licensee M0074 22. Name and Address of Facility Eline Funeral Home emmer 934 S. Main Street, Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5635 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b rector, page 2 sh 24a. Was an performed Ster 1 ☐ Yes 2 12 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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MD

32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MENDOZA

rnesto

31. Date filed (Month, Day, Year)

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5.18=20c.22 perFH. G883.9/9/08 WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 29,2008 August 1629 Dominique Derricott /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomero Grove Adventist HOSP. Shady If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 217-27-8456 **Funeral** Months Days Hours Min. 1 □ M 2 👿 F 22 May 27, Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be portified at Director 1 ☐ Yes 2√∑ No MD Montgomery Gaithersburg 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 201 Professional Drive 20879 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify \$ black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk student none marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othvany Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Dennis Derricott ဨ Rhonda Parker 19a. Informant's Name/Relationship (Type. Pript)
Rhonda Derricott (Mother)
Shady Crove Advent St Bosp Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 19 State **Ardent Crematory** 9-6-08 Hanover, MD 246 N Washington Street Rockville, MD 20850 21. Signature of Fit need Service thereae Walder, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2: autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) MD. 67238-8/29/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chini , Shedy Greene Holmontost Hespital again medical ctr. De., Ruckville 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 9 2008 SEP Registrar

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| | | | For 1 _ State | State of Ma | arylan | | artment of F r <i>tificate of</i> | | _ | 0 | 000 | 20067 |
|----------------------------|---|----------------|--|--|-------------|---------------------------------|---|-------------------------------|------------------------------|---------------|---|---|
| 1 | 100 | | State Registrar 1. Decedent's Name (First, Middle, | Last) | | Cei | lilicate of | Dealli | 2. Date of De | Reg. No | UUÖ | 3. Time of Death |
| ¥ | Physicia | | Estelle Cathe | | on I | Janor | ; | | Month Aug. 2 | 21, Day | 008 | 7:10 p ^M |
| | /Medic Examin | | 4a. Facility Name (If not institution, | | .011 | Janer | | r Location of Dea | | | ounty of Death | |
| | | | 11618 Riversho | | | | Dui | nkirk | | | Calve | |
| 100 | Funeral | | | 5. Sex 7. Ag 1 ☐ M 2 💢 F | | la <i>st birthd</i> ay) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | . (Month, Da | y, Year) | 9. Birth | hplace (State or Foreign untry) |
| ill | Director | | 579-16-9426 Usual Residence of Decedent | | 88 | 110. | | | 9/8/19 | 19 | | DC |
| | yland Iow at | | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | 10d. Inside City Limits |
| | a-fsh | cto | MD Ca: | lvert | | | Dui | nkirk | | | | 17∏Yes 2 ☐ No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizer | of What Co | untry? |
| | sath w s 23a nust b | | 11618 Riversh | | Cupy in 11 | C 12 | | 0754 | Procify Voc or No | | ISA Race - Amer | rican Indian |
| | item item | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie | 12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🔯 1 | | 5. 13. | Was Decedent of H If Yes, specify Cub | an, Mexican, Pue | rto Rican, etc.) | - 14. | Black, White | |
| 920 | urs af al', or xam | by | 3 X Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | | 1∐Yes 2∭XNo | Specify: | | Sp | pecify: W | hite |
| 21215-0036 | 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notifled at | Completed | 15. Decedent's (Specify only highest | Education grade completed) | | 16a. Dece | dent's Usual Occup | ation during most of we | orkina | 16b. Kind | of Business/I | Industry |
| 21 | within ene. | n ple | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | life. | kind of work done DO NOT use retire | | 9 | TT C | Corro | rnment |
| | be filed within 72 hours after death with the Marylan ital Hygiene. By other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | | 12 17. Father's Name (<i>First, Middle, La</i> | ast) | | | Secreta | | me (First, Middle, | | | Liment |
| and | ould be f Mental I narked of | o Be | Lawrence Dill | , | | | | | a Raley | | ,,,,,,,, | |
| Maryland | E E E | 욘 | 19a. Informant's Name/Relationship | | | 19b. Mailii | ng Address (Street | | | | own, State, Z | Zip Code) |
| Ž | nd 2 alth a 27 is | | Gerri Gable/D | aughter | | 3909 |) Lakesi | de Ct. | , Dunki | rk, l | MD 2 | 0754 |
| ore, | ges 1 a it of Hea if item or othe | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 | Pamoval from State | 20b. F | Place of Dispo emetery, cre | osition (Name of matory or other pla | ce) | Date | | tion - City or | Town, State |
| Ē | Page 1 | ١., | 4 □ Donation 5 🗓 Other (Spe | ecify) Entomb | s. | Memo | rial Gd | lns. 8/2 | 28/08 | Dunki | irk, N | MD |
| Baltimore, | permit. Pa Departmen Important: any Injury once. | | 21. Signature of Funeral Service Li | censee | | 2: F | 2. Name and Address $^{\circ}$ 0 Box $^{\circ}$ | ess of Facility Ra 30, Dur | aymond- nkirk, | Wood Md 20 | F.H., | , P.A. |
| 100 | r gy | | 23a. Part1. Enter the disease, or c shock, or heart failure. List o | omplications that caused | the death | | - | = | | | | Approximate Interval Between |
| S | Physician | | Immediate Cause (Final disease or condition | _a. Cong | esti | re 14 | eout F | adar | e | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | mmediate Cause (Final isease or condition estation) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events southing in death) a. Chapter (Least Fauluse) Due to (or as a consequence of): Due to (or as a consequence of): CKD (Monic Kidmer Disease) Due to (or as a consequence of): Chapter (Final isease) Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| S.An. | - Sec. 10 | - | Sequentially list conditions, if any, leading to immediate | b. Due to (or as | a conseq | uence of): | (White | avdin | Intacci | a) | | 5-10 |
| | uted d ansit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events | CK | (D) | (| Chranic | Kidne | e Dise | ace | 1 | Mlyr |
| oʻ | an an | | resulting in death) Last | Due to (or as | a conseq | uence o | | | 3 | | | d |
| 68760, | icate be executed physician and s the buriat-transit | edical | | d | | | | | | | | |
| | ± _ 0; | Mec | IF FEMALE: | 23c. If yes, outcome | nf progne | 2001 | | | | | 1 | |
| Box | death certi e attending d for use a | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 4 ☐ Pregnant a | 2 🗆 Feta | death 3 | ⊒Ectopic pregnanc ⊒Other <i>(sp</i> ec <i>ify)</i> _ | У | | 230 | Date of deli Month | ivery Day Year |
| P.O. | 0 0 | ysi | 1 ☐ Yes 26 € No 9 ☐ Unknown | 9□Unknown | | | | | | | | |
| | iaw requires that the as been signed by the 2 should be detache | by Pl | Part II. Other significant condition | s contributing to death b | out not res | ulting in the u | nderlying cause giv | ven in Part I. | 23e. Did t | obacco use | contribute to | the cause of death? |
| ıd | w require been sig should b | | | | | | | | 10 | Yes 2□1 | No 3∏Pr | obably 4 Unknown |
| ecc | e law n has be je 2 sh | Completed | | | | | | | 24a. Was | an 2 | 24b. Were au | topsy findings available completion of cause of |
| <u>~</u> | Th ate pag | Con | | | | | | | perfd 1□ Yes | rmed? | death? 1 ☐ Yes | 2 □ No |
| Vita | Physician: Th rthis certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | ot all poor Oth | oor: | eath (Check only o | | | |
| ō | | - To | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 1 ☐ Inpatie | | ER/Outpatier 28b. Time o | IL SELECT | 4 ☐ Nursing | Home 5 Resi 28d. Describe | | | cify) |
| O | Attending Phr r death. ector; After thi by the funeral. | tion | 1d Natural 5 ☐ Pending 2 ☐ Accident investiga | (Month, Da | | Injury | Wo | rk?]Yes 2 ∐No | | now injury o | 0001100 | |
| Division or Vital Records, | l or Atten after deatl Director; I in by the | ifica | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | | ury - At ho | ome, farm, st | reet, factory, office | | 28f. Location (| | vumber or Ru | ıral Route Number, |
| Ö | talors after all Direction | Certification: | T I I I I I I I I I I I I I I I I I I I | bullarily, et | | | | | Ony or ro | wii, Olale) | | |
| | To the Hospital or Attenwithin 24 hours after death To the Funeral Director: | edical | | Physician: To the best xaminer: On the basis of and manner st | of examina | | | | | | | |
| | To the within To the comple | Me | 29b. Signature and title of certifier | | | | 29c. Licens | se number | | 29d. Date s | signed (Monti | h, Day, Year) |
| | | | (att.) | Brus | | | Do | 4523 | 5 | 8 | 128/0 | 8 |
| ١٨ | w 8 | | 30. Name and address of person w | . / | | , , , , , | | | | | | |
| ar | | | Catherine Bro | phy, M.D. 32. Registr | | | wn Cent | er Blvd | l., Dunl | cirk, | MD 2 | 20754 |
| | Sta Registr | ar | 31. Date filed (Month, Day, Year) | 2 5 2008 | Robert | w K. | Sperk | 9 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 18:04 JOHN н. DAVIS /Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 50413641 NICOMICO ROOIOWAL MPOICAL TENINSULA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 06, 1912 9. Birthplace (State or Foreign 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🕱 M 2 🗆 F Months Hours 95 221-12-1580 ACCOMACK, VA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantual must be notified at 1 □Yes 2X No Director DELAWARE SUSSEX COUNTY FRANKFORD. DE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 38 19945 HONOLULU ROAD UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 □Yes 2X No Specify: Specify: BLACK Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) EDUCATION Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN (STATE UNIVERSITY) 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOHN** DAVIS TINGLE **JAMES** DAISEY ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B. AGNES MUMFORD (DAUGHTER) 38 HONOLULU ROAD, FRANKFORD, DE 19945 per it. Pages 1 and Decarment of Healt Important: If item 2 any injury or other Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State SEP 02,2008 WHALEYVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) WHALEYSVILLE CEM. 22. Name and Address of Facility 21. Signature of Funeral Service MO 1361 WATSON FUNERAL HOME, MILLSBORO, DE 19966 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complica Immediate Cause (Final disease or condition resulting in death) Ecoli Sepsis **Physician** 1 /Medical Due to (or as a consequence of): Examiner ITN Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed Be

certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

with

Baltimore, Maryland 21215-0036

h and Mental Fis marked oth

Health a

| | | | 24a. Was an autopsy performed? 1 |
|---|--|--|---|
| 25. Was case referred to medical | | 26. Place of Death (0 | Check only one) |
| examiner? 1 ☐ Yes 2 🔀 No | Hospital: 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 Nursing Home | 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation | (Month, Day, Year) Injury | Injury at 280 Work? 1 □ Yes 2 □ No | d. Describe how injury occurred |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify) | ice 28f | f. Location (Street and Number or Rural Route Number, City or Town, State) |

Medical 29b. Signature and title

29a. Certifier

(Check only one)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

(+5049)

29d. Date signed (Month, Day, Year) 24108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

PRMC. 100 E. Carroll St. Salisbury MD. 21801 m.D Chris Snyder 31. Date filed (Month, Day, Year)

BA 3 State

Registrar

Certification: To

AUG 2 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Year} 2008 **Physician** Georgia A. Dougherty 9:30 a August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 280 Skyview Rd. Elkton Birthplace (State or Foreign Country)
 NC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 M 2 F 76 October 20, 1931 215-56-1199 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21921 280 Skyview Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ₩idowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be ပ္ Beatrice Cornette **Everett Lewis** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 290 Skyview Rd., Elkton, MD 21921 Betty J. Fuller/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD Union Cemetery August 28, 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. levotio Heart Disease Immediate Cause (Final disease or condition resulting in death) Physician unknown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner anding physician and use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? Year) 5 Pending investigation nours after death.

neral Director: Ay filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: 24 hours a within 24 hor To the Fune completely fi

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S Sachder MD

8/26/2008.

29d. Date signed (Month, Day, Year)

Jackder 5 MD

118 North St Switz3B, Etken MD 21921

29c. License number

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 08:30 AM DRUMMONO L SAAC 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico REGIONAL MEDICAL SALISBURY ENINSULA 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 X M 2 □ F Months Hours 226-36-5332 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Modical Examinations to notified at Director 1 X Yes 2 □ No Wicomico PALISBURY MARULAND 10f Zip Code 10g. Citizen of What Country? 10e. Street end Number 21804 45A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Block 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NUNE 06 -ADOREE 12 should be filed wi th and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rummona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau bug STER E. 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ⊠Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee UN, HOME 82 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** anoxic disease or condition resulting in death) Muy days brain / /Medical Due to (or as a consequence of): Examiner hypogheemia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequente of) physician and s the burial-transit requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760, Physician/Medical use as t attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform certificate 2 🗆 No 1 □ Yes Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA After this Medical Certification: To ō funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Salichunguno B. hartes nth, Day, Year)
AUG 2 2 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 8 per fh g883 9-18-08 vt State of Maryland / Department of Health and Mental Hygiene 2 0 0 2887 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Davis Elaine SEPTEMBER 2008 7:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Page of Birth May Poorth, Day, Feb 12, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 □ F Director 219-54-1714 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County a or 28a-f show t be notified at show MD Allegany Cumberland V☐Yes 2☐No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA "natural", or items 23a 10301 Christie Road NE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married X Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify: Specify: ò 3 ☐ Widowed 4 ☐ Divorced white Completed iges 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nora Kathleen Hoadley Conners Francis William Conners ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rawlings MD 21557 18318 Platinum Road Patricia Colly sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/5/2008 Scarpelli Funeral Home, P.A. MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Fant : Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** carcinoma of /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 Alp
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury To the more after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check or one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa title of certifier

State Registrar 31. Date filed (Month, Day, Year) SEP 09 32 Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

2008

900 Seton Dr Cumberland MD 2502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep Registrar AMEND#9per INF,8-29-08,BWW,MbOo Ce | ertificate of | heaith and ivie <i>Death</i> | | ne _{No.} 2008 | 28872 | | | | | |
|----------------------------|---|-------------------|---|---|--|--|--------------------------------|--|--|--|--|--|--|
| | | | 1. Decedent's Name (First, Middle, Last) | | 2 | . Date of Death | | 3. Time of Death | | | | | |
| | Physici /Medio | | James Macon Evans, Jr. | | Αι | igust 22 | 2 2008 ear | 11:21 A M | | | | | |
| | Examir | er | 4a. Facility Name (If not institution, give street and number) | | r Location of Death | | 4c. County of Deat | | | | | | |
| | Funeral | | Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday | /) If Under 1 Year | nesda If Under 24 Hrs. 8 | . Date of Birth | Montg 9. Birt | | | | | | |
| | Funeral Director | | 173-18-0105 | Months Days | Hours Min. | Date of Birth (Month, Day, Ye Feb 21,19 | 19 Pen | hplace (State or Foreign untr W • VILGINI & nsylvania | | | | | |
| | yland now | | 10a. State 10b. County 10c. City, Town or L | .ocation | | | | 10d. Inside City Limits | | | | | |
| | e Mar | Director | Maryland Montgomery C | hevy Chase | e | | | 1 □Yes 2 🕅 No | | | | | |
| | or 28 | Dire | 10e. Street and Number | 10f. Zip Code | | 10g. | Citizen of What Co | untry? | | | | | |
| | ath w | ra | 2612 East West Highway | 208 | | | USA | | | | | | |
| 336 | within 72 hours after death with the Maryland Jishe. r than "natural", or items 23a or 28a-f show the Medical Exeminer must by mothlind at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II | | dispanic Origin? (Speci an, Mexican, Puerto Ric Specify: | ty Yes or No- can, etc.) | 14. Race - Ame Black, White | | | | | | |
| 9-0 | 2 hou | ted | 15. Decedent's Education 16a. Dec | edent's Usual Occup | pation | 16b | . Kind of Business/I | | | | | | |
| 21215-0036 | _ 0 | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | | during most of working d) | | | | | | | | |
| 121 | e filed withir al Hygiene. other than vent, the M | | | ial Worker | | | Social Wo | rk | | | | | |
| Maryland | ev d | Be c | 17. Father's Name (First, Middle, Last) James Macon Evans, Sr. | | 18. Mother's Name (Azle | | , | | | | | | |
| Z | € D = E | ို | | ling Address (Street | and Number or Rural F | | | (ip Code) | | | | | |
| | 12 tra | | 1 | | reet, Trent | | - | 08611 | | | | | |
| ore, | iges 1 and of Healt of Healt of Healt or other | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☒ Removal from State | oosition (Name of ematory or other place | Date | | . Location - City or | • | | | | | |
| Baltimore, | Z = e 2 | | 4 Donation 5 Other (Specify) Metropol: | itan Crema | atory 8/24/ | 08 A16 | exandria, | Virginia | | | | | |
| Bal | permit. Pa Departmer Important: any Injury once. | | | 22. Name and Addre | ^{ss of Facility} Fran Sity Blvd W | | | uneral Home g MD 20901 | | | | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line. | nter the mode of dyir | ng, such as cardiac or r | espiratory arrest, | | Approximate Interval Between Onset and Death | | | | | |
| - | Physician | | Immediate Cause (Final displayed on the condition of the cause of condition of the cause of condition of the cause of condition of the cause of the | | | | | | | | | | |
| | /Medical Examiner | | a. Due to (or as a consequence of): Segmentially list conditions b. Due to (or as a consequence of): | | | | | | | | | | |
| | | ē | Sequentially list conditions, in any, leading to immediate b. Due to (or as a consequence of): | | | | | | | | | | |
| D | cuted nd ransit | Examiner | is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | d StAO | e wine | - Canc | lh | | | | | | |
| , 0, | rificate be executed ig physician and as the burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| 68760, | cate b | ledical | d | | | | | | | | | | |
| | certific ding p | | IF FEMALE: 23c. If yes, outcome of pregnancy | | | | 2010111 | - 1 7 T- 1 | | | | | |
| O. Box | that the death cer | Physician/ | in the past 12 months? 1 Live birth 2 Fetal death 3 | ☐ Ectopic pregnanc ☐ Other (specify) _ | у | | 23d. Date of deli Month | very Day Year | | | | | |
| σ. | that t | Ph | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause giv | en in Part I. | 23e. Did tobaco | co use contribute to | the cause of death? | | | | | |
| rds | w requires to be a signal should be | ed by | | | | 1 ☐ Yes | 2 No 3 | obably 4 Unknown | | | | | |
| Division of Vital Records, | 6 % 0 | Completed | | | | 24a. Was an autopsy performed 1 □ Yes 2 ☑ | prior to death? | topsy findings available completion of cause of | | | | | |
| Vita | Physician: r this certific ral director, I | Be | 25. Was case referred to medical examiner? Hospital: | I ou | 26. Place of Death (0 | Check only one) | | | | | | | |
| j o | Phys | 은 | to result of the second of th | | 4 🗀 Nursing nome | | 6 Other (Spec | cify) | | | | | |
| o | Attending r death. ector: After by the funer | tion | Zinatural 5 | Worl | yat <br Yes 2 □No | d. Describe how in | njury occurred | | | | | | |
| Jivisi | | Certification: To | 3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st bullding, etc. (Specify) | | | Location (Street City or Town, St | and Number or Ru ate) | ral Route Number, | | | | | |
| _ | the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in | | 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or i | th occurred at the ti | me, date and place, an | d due to the caus | e(s) and manner as | stated. | | | | | |
| | To the H within 24 To the Fi complete | Medical | one) and manner stated. | | | | | | | | | | |
| C. | 2 +1 | - | 29b. Signature and title of certifier MXMLUM MD | 29c. Licens | HTAA | 29d. | Z2 OS |), Day, Year) | | | | | |
| 7 | • | - 1 | 30. Name and address of person who completed cause of death (Item 23a) (Type Melissa Lynn Means, MD 5508 Charles | | ethesda. M | D 20814 | | | | | | | |
| | Sta | | 31. Date filed (Month, Day, Year) Registrar's Signature | | concour, ri | 20017 | | | | | | | |
| | Registra | | AUG 2 5 2008 Beauty M. Aca | all s | | | | | | | | | |

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State 31. Date filed (Month, Day, Year)

Registrar AUG 2 5 2008

RAVI

15225 SHADY GROVE RD., SUITE 208, ROCKVILLE, MD. 20850
2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PASSI, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] [1] [3] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Elestine Patience Ennis August 18, 2008 1:30 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico 3555 Green Hill Church Road Quantico 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🖺 F 218-20-6279 9/24/1928 79 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" --- any injury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Director Maryland Wicomico Quantico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21856 USA 3555 Green Hill Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: Specify: þ white 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Delores White Charles Henry Landon Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3551 Green Hill Church Rd., Quantico, MD 21856 19a. Informant's Name/Relationship (Type. Print) Brenda J. Baumann/daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of Salem United Methodist 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/23/08 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery Thornow August Tuneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 . Signature of Funeral Service Licenses Dompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final py takic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only gne) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manny of Death 28a. Date of Injury (Month, Day, Year) Time of 28b. 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NIG 1 47094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

P.0.

Division of Vital Records,

NATESAN

AUG 2 2 2008

31. Date filed (Month, Day, Year)

1415

32. pgistrar's Signature

DIVISION SNEW

| | | | 1 - For State Registrar | State of Ma | ryland / | | artment of | | | ental Hy | gien Reg. N | .2008 | 28875 |
|---|--|-------------------------|---|--|-------------------------------|------------------------|---|---------------------------------|---------------------------|--|----------------|---|---|
| | Physic /Medi | cal | Decedent's Name (First, Middle, La Lawre Lawre 4a. Facility Name (If not institution, give | nce Arnold | FINEM | AN | 4b. City, Town | or Location | | 2. Date of De August | 23 | ay 2008 ^{ear} | 3. Time of Death 8:00 A M |
| , nu | Examii - - Funeral | ner | Montgomery General 5. Social Security Number 6. S | al Hospita | (In yrs. last i | birthday) | 01ne | y | | 8. Date of Bir | N | County of Death | |
| I | Director | | Usual Residence of Decedent | | 58 | Yrs. | Months Day | /s Hours | Min. | 8. Date of Bir (Month, Da Sept. | 15°, | 1949 Per | nnsylvania |
| | the Maryla 28a-f shov | ector | Maryland 10b. County Montgome | ery | 10c. City, To | ockv | ille | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | s 23a or | Funeral Director | 5032 Baffin Bay La | | | | 10f. Zip Code 208! | 52 | | | Uni | itizen of What Cou ted Stat | • |
| 0036 | within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Modical Experience must be redthed at | by | 11. Marital Status 1 X Never Married 2 Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: | ver in U.S. | | Vas Decedent of Yes, specify Cu | | igin? (Spe n, Puerto F | cify Yes or No Rican, etc.) | - | 14. Race - Amer Black, White Specify: Whi | , etc. |
| 21215-0036 | vithin | Completed | 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 | ucation de completed) College (1-4or 5+ |) | (Give I life. E | lent's Usual Occ kind of work don OO NOT use reti Worker | ne during mos red) | t of workin | g | | kind of Business/li | Workshop |
| 0 | 2 should be filed vorand Mental Hygie is marked other iranmatic event, tranmatic event | To Be C | 17. Father's Name (First, Middle, Last) Al I. Fine | | | | | 18. Mothe | | (First, Middle, | Maider | n Surname) | NOT KOHOP |
| , Mar | and 2 shu ealth and n 27 is m | | 19a. Informant's Name/Relationship (1 | | 13 | 329 F | g Address <i>(Stre</i> Pepper F | et and Numbe Road, J | er or Rural lenk i | Route Number | PA PA | or Town, State, Zi 19046 | ip Code) |
| Dallillore | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once. | | 20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 X☐ 4 ☐ Donation 5 ☐ Other (Specify |) | 20b. Place cemet Eterna | of Dispos ery, crem | sition (Name of latory or other pa ight Men | norial | 08/2 7 9 Gard | | | ocation - City or T ynton Be | • |
| , F | Physician /Medical Examiner | | 23a. Part 1. Int r the disease, or compshock, or heart failure. List only of disease or condition resulting in death) | olications that caused to one cause on each line a. HYPO Due to (or as a | XCMI consequence | not ente | DYCHTHSK 54 Carro or the mode of di 2051R/ | oll St. ying, such as | , NW | , Washi respiratory ar | nat | e on, DC | Approximate interval Between Onset and Death |
| The four contract the state of | physician and the burial-transit | dical Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (u. as a c. Due to (or as a d | | oi). | | | | | | | DAYS |
| | ned by the attending processing the standing processin | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown | Fetal deat | | Ectopic pregnar Other (specify) | ncy | | | | 23d. Date of deliv | very Day Year |
| | s been signed I | þ | Part II. Other significant conditions co | ntributing to death but | not resulting | in the und | derlying cause g | iven in Part I. | | | | | the cause of death? |
| The low | certificate has b ector, page 2 sh | e Completed | 25. Was case referred to medical | | | | | | | 24a. Was a autops perfor 1 Yes | ŠV | prior to co death? | opsy findings available ompletion of cause of |
| hyeicie | this cert | 10 B | examiner? 1 ☐ Yes 2 ☑ No | lospital: | | utpatient | 3 □ DOA Ot | hor | | Check only on 5 ☐ Reside | | 6 ☐Other (Speci | fy) |
| al or Attending | within 24 hours after death. To the Funeral Director: After this certification occupietely filled in by the funeral director; | Certification: | 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day, 1) 28e. Place of Injury building, etc. | | Time of Injury | M 1 | irk? ∐Yes 2.∐N - | lo | f. Location (Sincity or Town | treet an | d Number or Rura | al Route Number, |
| he Hoeni | in 24 hour he Funer pletely fill | Medical | 29a. Certifier 1 Certifying Phy check only one) 1 Medical Exami | siclan: To the best of ner: On the basis of e and manner state | xammanum a | e, death ond/or inve | occurred at the estigation, in my | time, date and opinion, deat | d place, an | nd due to the o | ause(s |) and manner as s I place, and due to | stated. o the cause(s) |
| Tof | Z vith | | 29b. Signature and title of certifier | | | | HC | se number | 061 | 2 | 9d. Dat | te signed (Month, | Day, Year) |
|) | | | 30. Name and address of person who co Deborch SHCIN, D. | 0 18101 | PriNO | | int) Philip De | rive | Olnei | JIMD | 20 | 832_ | |
| | Stat Registra | | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signature | A COL | £ 0 | | | | | | |

The law requires that the death certificate be executed Box 68760 attending phys for use as the bu Ö Records, P. certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, it Division of Vital

State

Physician/Medical X UNPENDED AMENDED 23a,27,28a-f per me g883 9-10-08 vt IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 / Inpatient 2 Other₄ FR/Outpatient 3 DOA Nursing Home 5 Residence 6 1 ✔ Yes No 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Pending Yes 2 X No unknown 8-14-2008 unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) $311 \;\; Golden \;\; Russett$ 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined (Specify) unknown Homicide Linden, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 23, 2008

111 Penn Street, Baltimore, MD 21201

OCME

Dr.

2008

Ana Rubio MD.

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien?

| | | | For State Registrar | State of Ma | aryland | / Depa | , Goos artmen <i>tificate</i> | t of H | ealth a | ind Me | | giene (Reg. No. | 008 | 2887 | 7 |
|---------------------|---|----------------|--|--|------------------------------|---------------------------------------|---|--------------------|------------------------------------|---------------------------|-------------------------------------|---------------------|--------------------------------------|--|-----------|
| | Dhuoisi | | 1. Decedent's Name (First, Middle, Last |) | | | | | | | 2. Date of Dea | ath | Year | 3. Time of Death | |
| | Physici /Medic | | Nona | | G: | ross | | | | | Aug. | 29, 2 | 2008 | 7:15 A | М |
| 1 | Examin | er | 4a. Facility Name (If not institution, give Calvert County | | g Cer | nter | | | Fre | | ck | | inty of Dea | | |
| | Funeral Director | | 5 7 ி ருவ இதுபார்கு முரு நூர் 6. Se | | e (In yrs. Ia 86 | | If Under Months | | If Under 2 Hours | 24 Hrs.] { | 8. Date of Birt | h Y, YPag 2 1 | 9. Bi | rthplace (State or Fore | ign |
| | D ≥ | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town or Lo | cation | | | | | | | 10d. Inside City Lim | its |
| | Aaryla I show | ō | MD Calve | rt | Too. Oity, | Lus | | | | | | | | 1 Tes 2 2 | |
| | with the has or 28e- | Director | 10e. Street and Number 12605 Olivet | | <u> </u> | | 10f. Zip | Code 065 | 7 | | | 10g. Citizen | of What C | Country? | |
| 920 | permit. Peges 1 and 2 should be filed within 72 hours eiter death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28e-f show says injury or other treumatic event, the Medical Exam an must be notified at once. | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Deceden! Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | | | Was Deced f Yes, spec | | | jin? (Spec , Puerto R | ify Yes or No- ican, etc.) | | Race - Am Black, Wh ecify B1 & | | |
| Maryland 21215-0036 | within 72 ho ane. then "natur | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | ication le completed) College (1-4or 5 | i+) | 16a. Deced (Give life. L | lent's Usua kind of wor DO NOT us Cook | | ition lu <i>ring m</i> ost) | of working | g | 16b. Kind o | | 1 | |
| land 2 | uld be filed dental Hygi rked other tic event, L | To Be Co | 17. Father's Name (First, Middle, Last) $Joseph$ | Gr | ау | | | | 18. Mother He1 | | (First, Middle, | Maiden Sui Kent | name) | | |
| Mary | ind 2 shou alth and N 27 is mei er treumai | | 19a. Informant's Name/Relationship (T) Veronica Wilmo | | hter | | | | | | Boute Number | | | Zip Code) | 2 |
| Baltimore, | Peges 1 annount of He | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) | | cer | ice of Dispo metery, cren tern | natory`or o | ther place | . 9 | Da /4/2 | 008 | | | or Town, State | |
| Balt | permit. Depertr Importe eny inji | | 21. Signature of Funeral Service Licens Blader G. | Sevrel | 1 | 1 4 | Name an | d Addres are | s of Facility S Be | Sew ach | ell F Rd.Pr | unera ince | l Ho Fred | ome 1.,MD2067 | 8 |
| | Physician /Medical | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only ol Immediate Cause (Final disease or condition resulting in death) | lications that caused ne cause on each line. | abr | For | | | | | respiratory ar | rest, | | Approximate Interval Between Onset and Death | |
| 8760, | The law requires that the death certificate be executed by the has been signed by the attending physicien and sage 2 should be detached for use as the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as Due to (or as Due to (or as | gel aconseque | hue ence of): | M. | y t | Fullest- | -c1 | | | | | |
| .O. Box 6 | that the death certific ed by the attending p detached for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal o | death 3 | Ectopic pr Other (sp | | | | | 23d | Date of d Month | elivery Day Year | |
| ο. | w requires that been signed b should be deta | þ | Part II. Other significant conditions co | | ut not result | ting in the u | nderlying c | ause give | en in Part I. | | | | | to the cause of death? Probably4 | |
| l Records, | | Completed | 9 | | | | | | | | 24a. Was autop perio 1 Yes | | 4b. Were a prior to death? | | ble of |
| /ita | sicien: The certificate ha | Be | 25. Was case referred to medical examiner? | Hospital: 4 Character | | | | 015 | | of Death | (Check only o | ine) | | | |
| Division of Vital | ding Phys | ilon: To | 27. Manner of Death Natural 5 Pending | 28a. Date of Inju (Month, Da | ry 2 | R/Outpatien 28b. Time of Injury | | 8c. Injury Work | Nu | 28 | e 5 Resid | | | pecify) | |
| Divisi | el or Attending s efter death. Il Director: After id in by the fune | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubulding, etc | ury - At hon c. (Specify) | ne, farm, str | eet, factory | | | | 8f. Location (\$ City or Tox | | umber or i | Rural Route Number, | |
| | To the Hospitel or Attent within 24 hours efter death to the Funerel Director: completely filled in by the | Medical C | (Check only 2 Medical Exami | sician: To the best ner: On the basis of and manner sta | examination | rledge, death on and/or in | vestigation | , in my op | oinion, dea | d place, ar th occurre | d at the time, | date and pla | ice, and di | ue to the cause(s) | |
| | To T com | Σ | 29b. Signature and title of contrier | M | | | | | number | 94 | 7 | 29d. Date s | gned (Mo | nth, Day, Year) | |
| | ϕ | | 30. Name and address of person who co | hur M. |). | | | Pri | nce | Free | leric | K, M | D 20 | 0678 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) SEP 0 9 2008 | 32. Registro | ar's Sigratu | ire force | W | • | | | , | 7 | | | |

| | | | 1 - For State Registrar | State of Mary | | artment o | | | | gien e (Reg. No. | 008 | 28878 |
|---|---|--------------------|--|---|--------------------------------|---|-----------------------------|------------------------|--|-----------------------------|-------------------------|--|
| | Dhoois | | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Date of De. Month | ath Day | Year | 3. Time of Death |
| | Physici /Medi | | Regime | (, , , , | ~ec | | | | S . | 23 | الأحداث | 1130 GM |
| F | Examir | | 4a. Facility Name (If not institution, give st | reet and number) | | 4b. City, To | wn, or Locati | ion of Death | | 4c. Cc | ounty of Death | ו |
| | | | Hobran Ho | ~~ | | 300 | Mark | . | | 0 | ند محر ه | mea |
| | Funeral | | 5. Social Security Number 6. Sex | M OFFICE | yrs. last birthday) | Months D | Year If Un Days Hou | der 24 Hrs. rs Min. | 8. Date of Bird (Month, Da March (| th y, Year) | 9 Birth | nplace (State or Foreigi |
| | Director | | Usual Residence of Decedent | ^{M 2AJF} 94 | Yrs. | | | | March 6 | , 191 | .4 PO | and |
| | land | | 10a. State 10b. County | 10 | c. City, Town or Lo | cation | | | | | | 10d. Inside City Limits |
| | Mary Heh | ţō | Maryland Montgomer | V | Rockv | illo | | | | | | 1 ☐ Yes 2 ☐ No |
| | r 28s | rec | 10e. Street and Number | J | NOOKT | 10f. Zip Co | ode | | | 10g. Citizer | n of What Co | untry? |
| | h witi | D E | 6121 Montrose Roa | d | | 20 | 0852 | | | Uni | ted St | tates |
| | ours efter death with the Marylar ref', or Heme 23a or 28a-1 ehow Exeminer mast be notified at | by Funeral Directo | 11. Marital Status | 2. Was Decedent Ever | r in U.S. 13. | Was Deceden | t of Hispanic | Origin? (Spe | ecify Yes or No Rican, etc.) | - 14. | Race - Amer | |
| 9 | or its | F | 1 Never Married 2 Married | Armed Forces? 1 Yes 2 No If Yes, Give | | 1 ☐ Yes X | | | rican, etc.) | | Black, White pecify: | white |
| 21215-0036 | within 72 hours efter death with the Maryland she. than "neturef, or iteme 23a or 28a-f ehow the Medical Examinar must be netitied at | Q P | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | | , | | | 3, | Jecny. | |
| 7 | n 72 | Completed | 15. Decedent's Educ (Specify only highest grade | | 16a. Dece | dent's Usual C kind of work of DO NOT use r | occupation done during r | nost of worki | ing | 16b. Kind | of Business/I | ndustry |
| 12 | with: | m C | Elementary/Secondary (0-12) | College (1-4or 5+) | | omemake | | | | ٥ | vn Home | 2 |
| | Hygin Hygin | Ö | 17. Father's Name (First, Middle, Last) | - | | Omemare | - 1 | other's Name | (First, Middle, | | | |
| an | ould be I Mental parked c | To Be | Hirsch Lindw | urm | | | | Tsyrl | (Unkno | own) | | |
| Maryland | 2 should be filed within 72 hours efter dea and Mantal Hygiene. is marked other than "neturef", or iteme raumatic event, the Medical Examination | - | 19a. Informant's Name/Relationship (Typ | e, Print) | 19b. Mailir | ng Address (S | treet and Nu | mber or Rura | i Route Numbe | er, City or T | own, State, 2 | ip_Code) |
| - | end 2 eeith a m 27 is | | Henry Gruner (son) | | 6608 | River | Trail | Court | , Beth | esda, | MD 20 | 0817 |
| Baltimore | -I 6 = | | 20a. Method of Disposition | 2 | Ob. Place of Dispo | sition (Name | of or place) | 0 | Date | 20c. Local | tion - City or | Town, State |
| Ĕ | Pages ment of ant: If its ury or o | | 4 Donation 5 Other (Specify) | moval from State | ling Davi | d Memoi | rial P | ark 08 | 3/24/08 | Bens | alem, | PA |
| alt | permit. Pag Depertment Important: eny injury o | | 21. Signature of Funeral Service Livense | | Tat | Petrins | koyss HE | Privew F | uneral | Home | | |
| _ | 20 F 2 9 | | | | | | | | , Washi | | , DC | 20012 |
| | | | 23a. Part1. En in the disease, or complice shock, or heart failure. List only one | ations that caused the cause on each line. | death. Do not ent | er the mode o | f dying, such | as cardiac o | or respiratory a | rrest. | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Balin | 0~2 | | | | | | | Onset and Death |
| 1 | /Medical Examiner | | resulting in death) | Due to (or as a co | | | | | | | | 0 0 00 |
| Н | 1 | - | Sequentially list conditions, b. | Sole | ensaguenna off | | | | | | | |
|) | pet lisit | Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to for as a co | us adnessus or). | | | | | | | |
| | and al-tra | xar | that initiated events c. resulting in death) Last | Due to (or as a co | insequence of): | | | | | | | |
| 8760, | The law requires that the death certificate be executed to has been signed by the ettending physicien and bage 2 should be deteched for use as the burial-transit | al | | | | | | | | | | |
| 9 | g phys as the | Physician/Medical | u. | | | | | | | | | |
| Вох | eath certific ettending p | 7 | IF FEMALE: 23b. Was decedent pregnant | c. If yes, outcome of p | | le | | | | 230 | d. Date of deli | very |
| | deati | Cla | in the past 12 months? | 1 Live birth 2 4 Pregnant at time | |]Ectopic pregr] Other (s <i>peci</i> i | | | | | Month | Day Year |
| P.O. | that the de led by the e deteched t | hys | 9 Unknown | 9□ Unknown | | | | | | | | |
| | res tha igned I be det | by | Part II. Other significant conditions cont | ributing to death but no | ot resulting in the u | nderlying caus | se given in Pa | art I. | 23e. Did t | obacco use | contribute to | the cause of death? |
| ord | w requir been si should I | ted | Diabetes The | r 2 | | | | | 10, | res 2√⊠i | No 3∏Pro | obably 4 Unknown |
| of Vital Records, | law r as be 2 sh | Completed by | Hyerters | | | | | | 24a. Was | | 24b. Were au | topsy findings available completion of cause of |
| <u> </u> | | Son | 7* | | | | | | | rmed? | death? | 2□No |
| /ita | clan: ertific ictor, | Be (| 25. Was case referred to medical examiner? | | | | 26. P | lace of Death | Check only | | | |
| = | Physician: this certificatal director, I | 2 | 1 ☐ Yes 2 ☑ No | spital: 1 Inpatient | 2 ER/Outpatier | | | Nursing Hor | me 5 Resid | dence 6 | Other (Spec | ify) |
| n n | ing P | | 27. Manner of Death 1-☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Ye | ar) 28b. Time of Injury | | Injury at Work? | | 28d. Describe I | now injury o | ccurred | |
| Sic | Attending r death. | cat | 2 Accident investigation 3 Suicide 6 Could not be | | | М | 1 ☐ Yes 2 | | | | | |
| Division | or A after of Direction by | Certification; | 4 Homicide determined | 28e. Place of Injury · building, etc. (S | At home, farm, str (pecify) | eet, factory, or | ffice | 1 | 28f. Location (S City or Tox | Street and N vn, State) | Number or Ru | ral Route Number, |
| _ | To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | | 29a. Certifier 12 Certifying Physi | cian: To the best of m | y knowledge death | | be the ended | | | | 4 | -1-1-1 |
| | 24 h | edical | (Check only 2 Medical Examinations) | er: On the basis of exa | mination and/or in | vestigation, in | my opinion, | death occurr | ed at the time, | date and pl | ace, and due | to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier | | | 29c. L | icense numb | er | | 29d. Date s | signed (Month | n, Day, Year) |
| • | | | トラーナン | Consi | | 2 | 050 | 1884 | | 8 | 22/2 | W77 |
| | 4 | | 30. Name and address of per sole o con | pleted cause of death | (Item 23a) (Type | | | | | - 1 | 2 12 | |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | , (-, poi | 1807 | | - W) | | 57 | 120 CM | an str |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's | - A | | | → <u>₽</u> 77 | | 9.10 | | ~ 60 A |
| | Regist | | AUG 2 5 2008 | Believ 1 | K Book | | | | | | | |
| D1.14 | JH 17 Dou 1/9 | 201 | | | D | | | | | | | |

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| | | | State of Maryland / Dep | artment of Health and I | , , | 0000 | 20070 |
|----------|--|----------------|---|--|-------------------------------------|-------------------------------------|-----------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last) | Tillicate of Death | 2. Date of Deat | eg. No. 2 U U 8 | 3. Time of Death |
| | Physicia | | Maria NMN Gruenwald | | Month | Day Year | 0700 AM |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | August | 19 2008 4c. County of Dea | |
| | LAGIIIII | CI | 20423 Chuck Lane | Hagerstown | | Washingto | |
| П | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, | | 8. Date of Birth (Month, Day, | | thplace (State or Foreign ountry) |
| | Director | | 230-74-0233 84 | | May 20,1 | 1924 Pol | land |
| | land Sw | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo | ocation | | | 10d. Inside City Limits |
| | Mary i-f sh | ţ | Maryland Washington County Hagerstow | n | | | 1 ∐Yes 2 X No |
| | r 28a | Directo | 10e. Street and Number | 10f. Zip Code | 1 | 0g. Citizen of What Co | ountry? |
| | th wit | | 20423 Chuck Lane | 21742 | | U.S.A. | |
| | r dea | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert | pecify Yes or No- o Rican, etc.) | 14. Race - Ame Black, Whit | |
| 0000 | s afte | by Fi | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ⚠ No If Yes, Give | 1 □Yes 2 X No Specify: | , | Specify: Wh | |
| Ş | hour Itural | | | dent's Usual Occupation | T | 16b. Kind of Business | /Industry |
| <u>.</u> | in 72 in "na Mudic | plet | (Specify only highest grade completed) (Give life. | kind of work done during most of wor DO NOT use retired) | king | | |
| 7 | d with | Completed | N/A Homem | aker | | Personal F | Residence |
| 2 | 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or items 2a or 28a-f show raumatic event, Ital Mudical Ever in the must be notified at | Be | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, M | * | |
| 2 | ould I Men Marke | ို | Gregor Zacharczuk | | acharczuk | | |
| 2 | 12 sh th and 7 is n traun | | | ng Address (Street and Number or Ru | | | Zip Code) |
| ָר ע | 1 and Healt tem 2 | | | 3 Chuck Lane, Hage | | MD 21/42 20c. Location - City or | Town. State |
| 5 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of the Hygiene. Department of | | Till buriar 2 Micremation 3 Li Removal from State | osition (Name of matory or other place) | 2008 | • | , |
| | mit. Foortar | | | rg Crematory 8-20 2. Name and Address of Facility Do | ouglas A. | mithsburg, Fierv Fur | <u>Maryiano</u> eral Home |
| ŏ | Departing Departing Important Lines and Ir. Conce. | | | 331 Eastern Blvd. | | | |
| | | | 23a. Part 1. Enter the disease, o complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. | ter the mode of dying, such as cardiac | or respiratory arre | est, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | disease - Lypo | via -hup | ver ha | Onset and Death |
| y. | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | |
| | LXammer | -K | b. Atrial thrown jf any, leading to immediate | p0212 | | | Zi day S |
| 1 | nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | Litation | | | 6 months |
| • | execting and jal-tra | Exal | that initiated events resulting in death) Last c. Due to (or as a consequence of): | (i lailed | | | G TOODS N |
| 20, | icate be executed physician and s the burial-transit | dical | La Diabetes | | | | 6-748415 |
| 0 | ntifice ng ph as th | Med | IF FEMALE: | | | | |
| 5 | ath ce ttendi or use | sician/Me | 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 | ☐ Ectopic pregnancy | | 23d. Date of de Month | livery Day Year |
| 5 | w requires that the death certific theen signed by the attending is should be detached for use as | ysic | 1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown | Other (specify) | | Worth | Day Teal |
| Ľ | that the post of t | , Phy | Part II. Other significant conditions contributing to death but not resulting in the u | Inderlying cause given in Part I. | 23e. Did tob | pacco use contribute t | o the cause of death? |
| Side, | uires n sign ild be | d by | Mild CHF | | 1 □ Ye | es 2 X No 3□P | robably 4 🗌 Unknown |
| Š | s bee | Completed | CAD | | 24a. Was a | n 24b. Were a | utopsy findings available |
| ב | The la | шо | | | autops | y prior to | completion of cause of |
| <u>a</u> | stan: | Be C | 25. Was case referred to medical examiner? | 26. Place of Dea | 1 ☐ Yes 2 ith (Check only on | - | 2 2 110 |
| 5 | hysic this co | To | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie | | ome 5 Reside | ence 6 □Other (Spe | ecify) |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | ion: | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) | Work? | 28d. Describe ho | w injury occurred | |
| 2 | death ctor: y the | icat | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st | M 1 □Yes 2 □No | 28f Location (St | reet and Number or R | tural Pouta Number |
| 2 | after after Direct | Certification: | 4 Homicide determined building, etc. (Specify) | | City or Town | | urar rioute reuniber, |
| • | ospita hours ineral ly fille | | 29a. Certifier Certifying Physician: To the best of my knowledge, dea | th occurred at the time, date and place | e, and due to the c | ause(s) and manner a | as stated. |
| | the Ho lin 24 the Fu | ledical | (Check only 2 Medical Examiner: On the basis of examination and/or in one) and manner stated. | nvestigation, in my opinion, death occu | irred at the time, d | ate and place, and du | e to the cause(s) |
| | Vith vith Con Con Con Con Con Con Con Con Con Con | Σ | 29b. Signature and title of certifier | 29c. License number | 2 | 9d. Date signed (Mon | |
| | | | , | D0061109 | 1 | 10724 2 | ω |
| 5 | H-1 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, | Print) | | | |
| Ĭ | Sta | | 31. Date filed (Month, Day, Year) AUG 2 8 2008 32. Sistrar's Signature | Code | | | |
| | Registr | ar | THOU IS COUNTY | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Manth 17/2008 1046ат м Patricia N. Gauci 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9 1/29 1 3 3 4 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗆 🛣 Guyana 076-50-0971 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Gambrills MD Anne Arundel 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 Winterhaven DR. 21054 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XXIo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify Indian Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Admin. Assistant United Propane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Montrose Beramsingh Lily Rambaram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Soumah Daughter 918 Winterhaven DR. Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/21/2008 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P.A. 17 12 Ridgely Ave. Annapolis, Md 21401 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final disease or condition resulting in death) duodena Due to (or as a consequence of): 120 anemio Due to tor e 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical **Examiner**

attending physician and for use as the burial-transit

signed by the a d be detached for

should b

has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

Director

Funeral

Completed by

Be

Examine

Physician/Medical

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Completed

Be

Certification:

Medical

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ★Yes 2 □ No

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital: 1 Inpatient 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Park Drive \$46 Gen Burnie my 21461 Mnacmeka MY 1411 31. Date filed (Month, Day, Year)

State Registrar

6 ☐ Could not be

determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Catherine Giannoni 1:50P.M /Medical AUGUST 31 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Boonsboro Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F Director 577-30-0131 82 28, 1926 Washington D.C Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No **Funeral Director** Maryland Washington <u> Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 625 Observatory Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Be Completed by Specify: 21215-003 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Registered Nurse</u> State Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Ρ. ပ Tillinghast Rose Catherine O'Brien 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Lino Giannoni / Husband 625 Observatory Dr. Hagerstown Maryland 21742 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 9/6/2008 Hagerstown, Maryland 21. Signature of Funetal Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction Acute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine viace cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗓 No this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed?
Ves 2 X No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending investigation filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d Date signed (Month, Day, Year) D44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 <u>DR. ZAFAR MALIK,</u> 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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TANNONT

DHMH 17 Rev 1/2001

Amend PI line a 25,27,28a-f, perME, g883 9/17/08 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 28882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 2008 **Physician** Month Thelma Evelyn Henderson 2105 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6: Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 90 218-24-1923 Director 08/28/1917 MDUsual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If E Marical Examine I rust be notified anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 932 Pennsylvania Avenue 21742 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ∐Yes 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Daniel Benjamin Blaine Henderson Mary Nancy Virginia Graham ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 932 Pennsylvania Avenue, Hagerstown, MD 21742 Irma M. Branch / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery | 08/30/2008 | Hagerstown, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Eunoral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Acute disease or condition resulting in death) 110213 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINER cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). red by the attending physician and detached for use as the burial-transit death certificate be executed Exami resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 movins? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy After this certificate Division of Vital 1 ☐Yes 2 ☐HO 2000 Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this, completely filled in by the funeral dii မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 5 ☐ Pending investigation 2 Accident 8/24/2008 unk 1 ∐Yes 2 👿 No subject fell 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 32 Pennsylvania determined 4 Homicide Home Ave. Hagerstown, MD Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check one) and manner stated. 29d. Date signed (Month, Day, Year) 8/26/0829b. Signa 29c. License number D58853 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 E ANTIETAM STREET, HAGERSTOWN, MD 21740 5H-6 CHOTANI HABIB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 7-038 Month **Physician** 32 PM arn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 15302 Greyfox Road Upper Marlboro Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 07/30/1945 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 X M 2 □ F Days 63 Wyoming Director 520~50~6500 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, 11- M-35al Event in it ust by notified a Director 1 ☐ Yes 2 No MD Prince George's Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 15302 Greyfox Road 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 🗓 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify à Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than accountant self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Andrew Helen ဂ္ Harbel Frances Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr Twyla L. Harbel, wife 15302 Greyfox Road, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolotan Crematory 08/25/2008 Alexandria, VA ure of Funeral Service Lice 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD elback Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ficate has been single page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 ☐ Yes 2 🙀 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address

f person who completed cause of death (Item 23a) (Type, Print)

910

32. Registrans Signature

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2008

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29c. License number

Sute 300 Anapolio MD

29d. Date signed (Month, Day, Year) 2000

State of Maryland / Department of Health and Mental Hygiene 28884 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Grace Lynn Hooper August 2008 10:30 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14 Cree Street Aberdeen Funder 1 Year | If Under 24 Hrs. Harford 8. Date of Birth (Month, Day, Year 11/23/1935 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 215_32_7439 1 □ M 2√2 F 72 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, tha Medical Ex-miner must be notified at 1 Yes 2 □ No MD Harford <u>Aberdeen</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Cree Street 21001 Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify: 3 ☐ Widowed 4 No Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalinda Lassie Lawrence Bowdoin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa J. Heaps (Daughter) 11752 High Point Rd. Felton, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R. A. Ferris & Co. 9/3/08 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liver 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arcinoma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed 2 10 la sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ MO ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | Ne Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havodognece, MD21078 IC. NAR, MID 01 Union 39. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 9 2008 State

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DHMH 17 Rev 1/2001

Registrar

08-06705 Glenda Hedrick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 28885

| ienoa riednok | | 1- For State Certifica | ite of Death | |
|--|---------------|--|--|--|
| Physici | an/ | Decedent's Name (First, Middle,Last) | | Reg. No. 2. Date of Death Month Day Year ADDO Inc. |
| edical Exami | ner | CHOISI | | August 30, 2008 1222 nrs |
| | | 4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center | 4b. City, Town, or Location of Death Glen Burnie | 4c. County of Death Anne Arundel |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth | day) If Under 1 Year If Under 24Hrs | |
| Director | | 217-58-0561 1 M 2 MF 57 | Yrs. Months Days Hours Min | 1-22-51 MARYLAND |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or | or Location | 10d. Inside City Limits |
| ≱ .# | _ | MD ANNEARUNDE GLE | AL RIDALIE | 1 Yes 2 No |
| staryland 28a-f show | ector | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| ith the Maryland 23a or 28a-f sho notified at once | ᡖ | 206 CEDAR DR. | 21060 | U.S.A. |
| ath wit items 2 | neral | 1 Never Married 2 Married Armed Forces? | Was Decedent of Hispanic Origin? (State of Yes, specify Cuban, Mexican, Puerto | |
| fter de l'', or i | y Fun | 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year | 1 Yes 2 No specify: | Specify: WhITE |
| hours after 'natural'', Examiner | ed by | d d | ecedent's Usual Occupation (Give kind of vuring most of working life, DO NOT use reti | |
| 36 nin 72 s. Ithan "dical I | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | ASE TECHNICIAN | Normatous |
| 5-00 ed with Hygiene other | Com | 17. Father's Name (First, Middle, Last) | | (First, Middle, Maiden Surname) |
| 21215-0036 uld be filed within 7 Mental Hygiene, marked other than | Be | HAROLD L. HEDRICK | | A LORRAINE SANDLES |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. item 27 is marked other than "natural", or items 23a or 28a-f shr traumatic event, the Medical Examiner, must be notified at once | ြ | | | Rural Route Number, City or Town, State, Zip Code) ENBURIE, MD-Z106 |
| 프 글 플 를 통 | | 20a. Method of Disposition 20b. Place of | Disposition (Name of cemetery, ry or other place) | Date 20c. Location - City or Town, State |
| imor Pages ment of tant: If or other | | Burial 2 Cremation 3 Removal from State A Denation 5 Other Specify: | | 4 08 HANOVER, MD. |
| Baltimore, permit. Pages 1 ar Department of He Important: If ite | | 21. Six aure d'Euperai Service Licensee | 22. Name and Address of Facility | USLERTY FAMILY FUSEARITOME |
| Physician | | 23a Part I. Enter the disease or complications that alised the death. Do not | enter the mode of dying, such as cardiac of | ASADEM, Mb · ZII 27- or respiratory arrest, shock, or heart Approximate Interval |
| /Medical | | failure. List only one cause on each line. | | Between Onset and lazepine intoxication Death |
| xaminer | | or condition resulting in death) Due to (or as a consequence of): | on course a someon | |
| | ē | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | |
| | amir | cause. Enter Underlying Cause (Disease or injury that initiated Levents resulting in death.) Last Due to (or as a consequence of): | | |
| cuted ind transit | EX | d | | |
| 760, icate be executed physician and the burial - transit | Medical | X unpended AMENDED23a,27,28a- | f, perME, g884 10/1 | 5/08 TT |
| 8760, ifficate be ng physic as the bur | n/Me | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy | Fetal death 3 Ectopic pregna | 23d. Date of delivery ancy Month Day Year |
| Box 687 ne death certific the attending p | Physician/ | past 12 months? 1 Yes 2 No 9 ✓ Unknown 0 Unknown 0 Unknown 0 Unknown 0 Unknown 0 Unknown 0 Unknown | Other (Specify) | |
| P.O. Be that the de ned by the detached f | Phy | Part II. Other significant conditions contributing to death but not resulting | in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |
| ires that the signed by I be detached | d by | | | 1 Yes 2 No 3 Probably 4 Unknown |
| Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be | Completed | | | 24a. Was an autopsy findings available prior to completion of cause of |
| Recc The lar cate ha | mo | | | performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No |
| 1 of Vital Reco ling Physician: The law After this certificate has funeral director, page 2 s | BB | 25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Out | 26.Place of Death (Check toatient 3 DOA Other, Nursin | |
| of Viing Physi After this | <u>P</u> | 27. Manner of Death 28a. Date of Injury 28b. To | tpatient 3 DOA Other 4 Nursin | ng Home 5 Residence 6 Other: 28d. Describe how injury occurred |
| ision of Attending ar death. The true funding by the funding and a sector are the funding and a sector are funding and a sector are funding and a sector are funding as a sector are funding as a sector are funding as a sector are funding as a sector are funding as a sector are funding as a sector are funding as a sector are a sec | ertification: | 1 Natural 5 Pending Fnd 8/30/08 unl | 1 Yes 2 X No | unk |
| ivisi or Att after de Direct | tifica | 3 Suicide 6 X Could not be 28e. Place of Injury - At home, far | m, street, factory, office building, etc. | 28f. Location (Street and Number or Rural Route Number, City or Town, State) unk |
| Dospital hours a meral y filled | O | 4 Homicide (Specify) | | |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as it | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or in | | |
| To wir | Me | and manner stated. 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| | | anesz' | O.C.M.E. | September 3, 2008 |
| | | Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 P | enn Street, Baltimore, MD 2120 | 1 |
| S | ate | 31. Date filed (Month, Day, Year) 32. Repstrar's Signature | Sim Greet, Baltimore, IVID 2120 | |
| Renis | | | March Alle | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 16:51 PM 08 Raymond Clarence Jones 08 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death. WICOMIC SALISBUM PENINSULA REGIONAL MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07.28.1925 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 1 M 2 □ F Months Days Hours 218.20.2838 83 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛂 🕶 1 Caroline Maryland Preston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5980 Newton Rd., Lot R 8 21655 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Jones Mildred Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Jones Young/Niece 5980 Newton Rd., Lot R 8, Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 08.26.2008 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 21 Sanature of Funeral Service Licensee ^{22 Name and Address of Facilit} Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCALDIAC 7 CUTE Due to (or as a consequence of): DRONABY WEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 NO 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

900-31-15 P.O. Box 68760 Records.

Division of Vital Raymond

ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu Medical 101 veteran

6UTTORNEZ

6 ☐ Could not be

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00062916

1 ☐ Yes 2 ☐ No

30. Name and a ress of reson who completed cause of death (Item 23a) (Type, Print)

and manner stated

SOUTH PIVISION SINITE B SACISTARY NO 21804 1415 trar's Signature 31. Date filed (Month, D

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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Certification: To

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 🗌 Homicide

29b. Signature and title of certifier

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor Injury or other traumatic event, the Mydical Exyril Mr. 1 ust be rightled at

Department of Health a Important: If Item 27 is any Injury or other trau <u>once.</u>

Physician

/Medical

Examiner

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ned by the a

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death with the Maryland

filed within 72 hours after

Pages 1 and 2 should

3altimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.

AMEND ITEM 18, perf H, G883, J/10 708, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 4, 2008 **Physician** 5:42 PM LAMPIN-RIVAS **FERNANDO** JOSE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 x M 2 □ F N/ADirector Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f showing the confidence of XXYes 2 □ No Frederick Maryland Frederick Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hydene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, Ita Marical Extrainst Para once. USA 21702 1418 West 11th Street Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 Specificentral America Specify: Non White YMYes 2 □ No <u>გ</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marely del Rosario Rivas Ernesto Jesus Lampin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1418 West 11th Street, Frederick, MD 21702 Marely D. Rivas, mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Sept. 6, 2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 MOO255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DIAPHRAGMATIC HERNIA AT BIRTH /Medical Due to (or as a consequence of) AT BIRTH Examiner MULTIPLE CONGENTIAL ANOMALIES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CONFIRMATION PENDING BIRTH the Hospital or Attending Physician: The law requires that the death certificate be executed TRISOMY (8 attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by DYSMORPHIC REATURES, SEVERE GROWTH 1 Yes 2 No 3 Probably 4 Unknown RETARDATION, HYPOSPA-DIAS, ABNORMAL 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate ha BONY STRUCTLIRES THORAX, ABNORMAL VERTEBRAGOYES 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Magner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number SEP 04, 2008 D 39805 400 W 7-TH STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Staté Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

FREDERICK MEMORIAL HOSPITAL NICH

FREDERICK IND 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 28888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Layman September 2008 Naomi Louise 8:10pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nusring Center Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 216-24-1327 79 Sep 18, Maryland Director Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits show injury or other traumatic event, the Medical Examinar must be notified at Frederick 1X Yes 2□No Director Maryland Frederick 28a-f 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number "natural", or items 23a or U.S.A. 21701 1601-A Berry Rose Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Administative Financial permit, Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatte. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthor Waltz Runkles Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George M. Layman, Jr, Husband 1601-A Berry Rose Ct, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sep 5, 2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility ford P.A. Funeral Home 21. Signatury of Funeral Service Licer 106 E Church Street, Frederick, Maryland 21701 M00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considuence off Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the 38 IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has page 2 autopsy Hospital or Attending Physician: The this certificate 2/ Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes ~ ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of eath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 2 ☐ Accident 5 Pending investigation death. 1 □Yes 2 □No 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and litle of certified 29c. License numbe 29d. Date signed (Month, Day, Year) ٥

State Registrar 30. Name and address

filed (Month, Day,

SEP

Year)

9 2008

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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 08 08 0250 /Medical MARIE LARRICK 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CUMBERLAND nder 1 Year | If Under 24 Hrs. ALLEGANY WMHS BRADDOCK CAMPUS 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Jul 17, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1938 1 □ M 2 □ F 218-34-2508 70 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Allegany MD Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 1101 Kentucky Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 Specify. Specify: ò white 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hostess Holiday Inn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Lacy B. Cifala Mary Ballarion Cifala ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Smitco Road Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Bruce Sm ith son Place of Disposition (Name of cemetery, crematory or other place)
 St. Mary's Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 → Burial 2 □ Cremation 3 □ Removal from State 8/30/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeral Service Lice. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or co-shock or heart failure. List on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician mouth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 □Yes 2 No within 24 hours after death.

To the Funeral Cirector After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: Monatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) D46346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tuenue Cumberland Kent Muma

State Registrar 31. Date filed (Month, Day, Year)

0 9 2008

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of Mar | | partment of H ertificate of I | | | ene 2008 | 28890 |
|-------------|---|----------------|---|---|--------------------------------|--|--|------------------------------------|---|--|
| g. | Physicia | | 1. Decedent's Name (First, Middle, Last) | - | | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | /Medic | - | | | Meeks | th Oir Town a | Leasting of Dooth | August | 24 2008 4c. County of Death | 3:25 P M |
| | Examin | er | 4a. Facility Name (If not institution, give s 8934 Frederick Ave | | | North | Location of Death Beach | | Calver | rt |
| Cutate | Funeral | | 5. Social Security Number 6. Sex | 7. Age (| In yrs. last birthd | | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | | lace (State or Foreign try) |
| fui- | Director | | 214-64-9/53 | M 2□F52 | Yrs | . Months Days | Tiodio Isini. | 12-14-19 | 955 Wash | ., D.C. |
| | and w t | 1 | Usual Residence of Decedent 10a. State 10b. County | 1 | 0c. City, Town or | Location | | | 1 | 0d. Inside City Limits |
| | Mary Fied a | tor | MD Calvert | | | North | Beach | | | 1 Tyes 2 □ No |
| | th the or 28s e noti | Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of What Coun | try? |
| | ath wi | | 8934 Frederick Av | | | 20714 | | | USA 14. Race - Americ | an Indian |
| | ter de items iner m | Funeral | 11. Marital Status 1 ☑ Never Married 2 ☐ Married | 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 📆 No | er in U.S. | Was Decedent of H If Yes, specify Cuba | ispanic Origin? (Sp an, Mexican, Puerto | Rican, etc.) | Black, White, | |
| 21215-0036 | be filed within 72 hours after death with the Maryland Hylgiene. Ad other than "natural" or Items 23a or 28a-f show event, the Medical Examiner must be notified at | þ | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 📉 No | Specify: | | Specify: wh | ite |
| 2-0 | 72 ho 'natur dical | eted | 15. Decedent's Educ (Specify only highest grade | cation e completed) | (G | ecedent's Usual Occup | during most of work | king 1 | 6b. Kind of Business/Inc | dustry |
| 121 | within ene. than ' | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | ı | e. DO NOT use retired oofer | 1) | | construct | ion |
| Q 2 | filed Hygid other ent, th | Be Co | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | e (First, Middle, M | laiden Surname) | |
| /lan | should be filed and Mental Hygi s marked other umatic event, ti | To B | Lewis Frank | Meeks | | | Shirle | y Ann | n Fitzge | erald |
| Maryland | 2 sho and I is ma rauma | ľ | 19a, Informant's Name/Relationship (Ty) | | | | | | City or Town, State, Zip | , |
| e) (e) | 1 and Health em 27 ther t | | Deborah J. Wells, | Personal | | sposition (Name of crematory or other place | | | 20c. Location - City or To | |
| altimore, | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. | | 1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | | crematory or other plac olitan Crei | 4 | 27-08- | Alexandria | . VA |
| al‡ | mit. F partm portar y injur | | 21. Signature of Euneral Service License | ee C | TICCTOP | 22. Name and Addre | ss of Facility R | ausch Fur | neral Home, | P.A. |
| <u> </u> | an De la la la la la la la la la la la la la | 11 | William | Gio | 9 | | | | ngs, MD 2073 | 36 |
| 1 | Physician /Medical | 6 19 | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | ne cause on each line. | consequence of): | 19 (| ances | | st, | Approximate Interval Between Onset and Death |
| | Examiner | | Sequentially list conditions, | | | Χ. | | | | |
| | ted sit | nine | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | Due to (or as a c | consequence of): | | | | | |
| , | execu n and ial-tra | Examiner | that initiated events cresulting in death) Last | Due to (or as a | consequence of): | | | | | |
| 58760, | ficate be executed physician and is the burial-transit | dical | | l | | | | | | |
| | certifica ding ph | | IF FEMALE: | 3c. If yes, outcome pf | pregnancy | 170 | | | Ond Date of delive | |
| P.O. Box | Atter ding Physician: The law requires that the death certific rotesth. cctor After this certificate has been signed by the attending is by the funeral director, page 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown | Fetal death | 3 □Ectopic pregnanc 5 □ Other (specify) _ | <i>y</i> | | 23d. Date of delive | Day Year |
| ٠ <u>;</u> | uires that the de signed by the a ld be detached fi | by Ph | Part II. Other significant conditions con | ntributing to death but | not resulting in th | e underlying cause giv | en in Part I. | 23e. Did tob | acco use contribute to t | he cause of death? |
| ıds | w require been sig should by | | | | | | | 1 □ Ye | es 2 No 3 Prot | pably 4 □Unknown |
| Records, | law re las be | Completed | | | | | | 24a. Was an | y prior to co | ppsy findings available mpletion of cause of |
| E H | ysician: The lav nis certificate has director, page 2 | | | | | | | perform 1∐ Yes 2 | ned? death? No 1 □ Yes | 2 □ No |
| Vita | sician certifi irector | Be c | 25. Was case referred to medical examiner? 1 Yes 2 No | lospital: 1 ☐ Inpatient | 2 D ER/Outpo | atient 3 DOA Oth | or: | th (Check only one | | 5.3 |
| ō | ding Phys h. After this funeral di | n: To | 27. Manner of Death | 28a. Date of Injury (Month, Day | 28b. Tim | ne of 28c. Injur | | | nce 6 Other (Special winjury occurred | 9) |
| NO. | arh. or After he funer | atio | 1 Natural 5 Pending investigation | (World), Day | <i>Year)</i> Inju | | Yes 2 □ No | | | |
| Division or | or Atter fter deal irector in by the | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of injury building, etc. | / - At home, farm (Specify) | , street, factory, office | | 28f. Location (Str City or Town | reet and Number or Rur , State) | al Route Number, |
| | To the Hospital or Atterwithin 24 hours after dead To the Funeral Director completely filled in by the | | (Check only 2 Medical Exami | ner: On the basis of e | xamination and/o | | | | ause(s) and manner as s ate and place, and due t | |
| | o the ithin 2 o the omple | Medical | one) 29b. Signature and title of certifier | and manner state | ea. | 29c. Licens | e number | 29 | 9d. Date signed (Month, | Day, Year) |
| | ⊢ <i>s</i> ⊢ ö | | • | Alfant - | -6 | D | 4624 | 6 1 | August 2 | 62008 |
| 100 | .) ^ | | 30. Name and address of person who co | | , , , - | | , | 1013 | 1 5 11- | 6,2008 D 20603 |
| ak! | V 4 | | 31. Date filed (Month, Day, Year) | 32. Registra | ELU Signature | ND | U | PLDE | ILF M | D 20003 |
| | Sta Registi | | | 0 | esian k | 4. Sperke | 8 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 22 Sylvester George Macis 2005 8:00 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Raltimore County 3922 Mount Zion Road Upperco If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Min. Months Days Hours 218-22-9393 79 5, 1928 Maryland NOV. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland Baltimore County Upperco 1 □Yes 2 No 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21155 3922 Mount Zion Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married white 1 ☐ Yes 2 🕱 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) construction building contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sylvus Xaveras Macis Helen Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daria M. Rider - Daughter 1582 Dellsway Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Date 20c. Location - City or Town, State 20a. Method of Disposition Aug. 23, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hampstead, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fline Funeral Home 934 South Main Street M01072 Hampstead, Maryland 21074 Approximate Interval Between Onset and Beat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 5

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

s 23a or 28a-f show ust be notified at

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, Its Invalical Ext. (In Its Invalical Ext. (In Its Invalical Ext. (In Its Invalica

72 hours after

Pages

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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/Medical

burial-trar attending for use as signed I I be det page

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

After the Hospital or Attending ithin 24 hours after death.

the Funeral Director: A
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within 7 0 WJZ

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. ARTERIESCEROTIC AR Due to (or as a consequence of): C. Due to (or as a consequence of): d. | plovate DIS | 20 YEN |
|--|--|---|---|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | 23d. Date of Month | delivery Day Year |
| | ontributing to death but not resulting in the underlying cause given in Part I. | 24a. Was an 24b. Were autopsy performed? | Probably 4 Unknown a autopsy findings available to completion of cause of th? |
| 25. Was case referred to medical | 26. Place of Death | 1,5100 | Yes 2□No |
| examiner? | Hospital: Other: | me 5 Residence 6 □ Other (5 | Specify) |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury (Month, Day, Year) 28b. Time of light of Work? M 1 □ Yes 2 □ No | 28d. Describe how injury occurred | |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number of City or Town, State) | r Rural Route Number, |
| | ysiclan: To the best of my knowledge, death occurred at the time, date and place, ilner: On the basis of examination and/or investigation, in my opinion, death occurr | | |

State Registrar 31. Date filed (Month, Day,

nd title of certifier

29b. Signature

30. Name and address

Year) AUG 25 2008

OSENBLUM

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

1600 04

29c. License number

29d. Date signed (Month, Day, Year)

10f. Zip Code

21771

1 ☐ Yes 2 No

4b. City, Town, or Location of Death

Mount Airy
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

<u>A</u> M

4c. County of Death

10g. Citizen of What Country?

Date of Birth (Month, Day, Year)

July

20,

USA

Carroll County

1920 Pennsylvania

14. Race - American Indian,

Black, White, etc.

Specify: White

Birthplace (State or Foreign Country)

10d Inside City Limits

1 ☐ Yes 2 X No

21771

Approximate Interval Between Onset and Death

Year

Years

Years

Years

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23d. Date of delivery

Month

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 1:30 25, Dorothy May McGivern August

7. Age (In yrs. last birthday)

88

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give

10c. City, Town or Location

Mount Airy

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 X F

Lorien of Mount Airy

5. Social Security Number

171-14-0059

10e. Street and Number

10a, State

Director

Funeral

Usual Residence of Decedent

Maryland Frederick

1 Never Married 2 Married

12889 Colonial Drive

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ex. miner must be notifiled at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and attending physician as the the ģ has this

The law requires that the death certificate be executed or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division or Vital Records, P.O. Box 68760,

þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker China Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Herbert Morgan Elizabeth Matilda James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Flood, daughter 12889 Colonial Drive, Mount Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5 ☐ Other (Specify) Metropolitan Crematory 8/26/2008 | Alexandria, Virginia 21. Signature of uneral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Int-ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or eart failure. List only one cause or each line. Immediate caus (Final disease or sand ion resulting in de iii) Osteoporosis Due to (or as a consequence of): Failure of Thrive 2° Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hypertention < Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Chronic Obstructive Pulmonary Disease IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anemia, Osteoarthritis, Diabetes type II, Completed 24a. Was an Aortic Immobility Syndrome, Aneurysms autopsy performed? Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pendina Injury 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signature D54749 August 25, 2008 30. Name and address of person who completed cause Th (Item 23a) (Type, Print)

> House 32. Registrar's Signature Toal

801

State Registrar Allen Reilly, MD,

AUG 2

31. Date filed (Month, Day, Year)

House Avenue, D-1, Frederick, Maryland

State of Maryland / Department of Health and Mental Hygiene

2008 28893

| c. | | 1- For State Registrar | Certificate of Death Reg. No. | | | | | | | | | | | |
|---|--|--|--|---------------------|---------------------------------|---|-----------|-----------------------|-----------------------|------------------------------------|---------------|---------------------|--------------------|--|
| Physicia "cal Exami | an/ | 1. Decedent's Name (First, Middle,Last) Joanne White Mitchell | | | chell | Month | | | | Date of Dea Month August 19 | f Death 3. | | | 3. Time of Death 0823 hrs |
| | | 4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center | | | | 4b. City, Town, or Location of Death Salisbury | | | | 4c. County of Death Wicomico | | | | |
| Funeral | | Social Security Number | | 7. Age (In yrs | . last birthday) | If Under | 1 Year | If Under | 24Hrs. 8 | 8. Date of Bi | irth(MM/DI | D/YYYY) | 9. Birth | place (State or |
| Director | | 217-42-5802 | 1 M 2 X F | | | | Days | Hours | Min. | 05/14 | , | Foreign | | |
| > : | | Usual Residence of Decedent 10a. State 10b. County | | Inc. Ci | ty, Town or Loca | ation | | | | | | | | 10d. Inside City Limits |
| daryland 28a-f show any 1 at once. | ٦ | | omico | | Villards | | | | | | | | | 1 Yes 2 X No |
| death with the Maryland or items 23a or 28a-f sho must be notified at once. | Director | 10e. Street and Number 9132 Bethel Road | | | 10f. Zip Code 21874 | | | | | 10g. Citizen of What Country? USA | | | ry? | |
| uth with th tems 23a st be noti | -1 | 11. Marital Status 1 Never Married 2 M | 12. Was Dec | | | /as Deceden Yes, specify | | | | | 0- 1- | 4. Race - White, | | an Indian, Black, |
| after de: al", or i | by Fu | 3 X Widowed 4 Div | 1 Yes vorced If Yes, Give Year or Dates: | | 1 | Yes 2 | | | | | | pecify: | whi | |
| hours a "natural Examin | pleted | 15. Decedent's Education (Spe Elementary/Secondary (0-12) | | | 16a. Decede during | ent's Usual C most of work | | | | | 16b. Kir | nd of Busi | iness/In | dustry |
| 5-0036 led within 72 tygiene. other than ' | | 12 | 2 | | grou | ıp lea | | | | | | ove I | Poin | ite |
| 21215-0036 July be filed within 7 Mental Hygiene. marked other than c event, the Medica | | 17. Father's Name (First, Middle Charles Henry | | | | | 18 | | , | irst, Middle, Harri | | urname) | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Flygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once | | 19a. Informant's Name/Relations Susan M. Ryan | | | | ng Address Beth | (| | | | | | , State, | Zip Code) |
| re, re, land Healt Fitem | | 20a. Method of Disposition 1 Burial 2 X Cremation | n 3 Removal fro | | p. Place of Dispercematory or o | osition (Namother place) | e of ceme | etery, | С | Date | 20c. Lc | cation - (| City or 1 | own, State |
| Baltimore, permit. Pages I as Department of Her Important: If ite | | 4 Donation 5 Other S | pecify: | S | alisbur | y Cren | | - | 8/21 | | | lisb | | |
| Balti permit. Departm Imports injury o | | k land H. | Common | 70 C | FSP 5 | iollow 01 Sn | ay Fi | unera ill E | al Ho | ome Pr Salis | ofess bury | siona , MD | al A 218 | ssociation 04 |
| Physician /Medical | | 23a. Part I. Enter the disease, or failure. List only one cause | r complications/that ca e on each line. | aused the dea | th. Do not enter | the mode of | dying, su | uch as car | rdiac or re | espiratory ar | rrest, shock | k, or hear | rt | Approximate Interval Between Onset and Death |
| ćxaminer | aminer | Immediate Cause (Final disease or condition resulting in death) | a. Torso Injuri Due to (or as a | | e of): | | | | | | | | | Death |
| | | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | | | | | |
| | | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | |
| 760, cate be executed physician and the burial - transit | | UNPENDED | dAMENDED | | | | - | | | | - | | | |
| O, e be e ysicia buria | edical | | | | | | | | | | 1004 | Data of a | lali | |
| an 00 an | 51 | IF FEMALE: 23b. Was decedent pregnant in t | | outcome of projects | | etal death | 3 | Ectopic | pregnanc | v | | Date of d Month | - | av Year |
| Box 687 ne death certific the attending perfection of the control | Physicia | past 12 months? | 4 Pregn | nant at time of | -1 | Other (Speci | | | programa | , | | | | , |
| Bo e deat | nys. | 1 Yes 2 No 9 Un | known g Unkno | own | | | | | | | | • | | |
| ires that the signed by I be detached | þ | 1 Yes 2 ✔No 3 Pro | | | | | | | _ | | | | | |
| ords, w require s been si | Completed | | | | | | | | | 24a. Was | s an | | | opsy findings available |
| COT law r has b | 롈 | | | | | | | | | | ormed? | | ior to co eath? | ompletion of cause of |
| Vital Rec ysician: The his certificate | S | | 4 | | | | | | | 1 🗸 Yes | 2 No | 1 | ✓ Yes | 8 2 No |
| tal cian: certil | Be | 25. Was case referred to medical examiner? | Hannital . | | - | | 10 | of Death (0 other: | | |] | | lou. | - |
| of Viring Physical After this | ဥ | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date | | ✓ ER/Outpatie 28b. Time o | | | at Work? | Nursing I | Bd. Describe | Residen | | Other: | _ |
| ion of Vital Records, P.O. Box 68 tending Physician: The law requires that the death certifeath. tor: After this certificate has been signed by the attendin the funeral director, page 2 should be detached for use as | ation: | 1 Natural 5 Pen | ding Aug 19, | Day Year) | 0742 hrs | injury 2 | | es 2 🗸 I | lD: | river in ar | | | | n |
| Division of Vital Records, ral or Attending Physician: The law requir rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to be a second the funeral director. | Certification: | Accident Investigation Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State) Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Rt 50/Civic Avenue, Salisbury, | | | | | | | al Route Number, City | | | | | |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Medical C | 4 Homicide Capacity Major Road / Figriway Int Solicity Average, dailsbury, Mid- 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | | | | | | | |
| To T To t | | 29c. License number | | | | 29d. Date signed (A | | | | | | | | |
| | | Pagaet Ra. | theil ins. | 0 | | | O.C.M | I.E. | | | Augu | ıst 20, : | 2008 | |
| 13gu | 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | | | |
| S | tate | | | strar's Sign | ature | 6 | | | , ,,,, | | | | | |
| Regis | | 31. Date filed (Month, Day, Year) AUG 2 | 2 2008 | Elem | 1 1 | marke | , | | | | | | | |

Box 68760, P.O. Division of Vital Records, hours after death

within 24 hours a

To the Funeral I

Registrar

State

31. Date filed (Month, Day, Year) AUG 25 2008

Genévieve Wroblewski, MD

29b. Signature and title of certifier

(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0064615

6001 Muncaster Mill Road, Rockville, MD 20855

29d. Date signed (Month, Day, Year)

August 21, 2008

08-06520 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Donna Marie Newlon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner Donna Marie Newlon 0703 hrs August 26, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13544 Pectonville Road Big Pool Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** cou**Maryland** Davs Hours Director 1 M 2 XF 37 07/25/1971 218-17-8108 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Yes 2 X No notified at once, Maryland Washington Bia Pool Director 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country 13544 Pectonville Rd. 21711 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed 4 Specify: White ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) the transfer of the transfer o Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Shift Manager Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Bernard Garson Adkins, Sr. Barbara Jean Toombs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Newlon, Jr. - Husband 13544 Pectonville Rd. Big Pool, Maryland 21711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Department c Important: Smithsburg Crematory Aug. 28, 2008 Smithsburg, Maryland Other Specify: -Donation 5 As Nome and Address of Facility Home. P.A. ignature of F 425 S. Conococheague St.Williamsport, MD Tart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Cardiomegaly Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last andtransi Physician/Medical AMENDED PI line a-b, 27. per ME g883 9/11/08 TT the attending physician ed for use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 Residence 6 V Other: Scene ပ္ 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: d in by the f Yes 2 Pending hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide within 24 hours at determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registra

30. Name and address of person who

31. Date filed (MorAUG, Year)

Pamela E. Southall, MD

completed cause of death (Item 23a)

2008

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 27, 2008

| Physician | |
|-----------|--|
| /Medical | |
| Examiner | |
| | |

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Physician

Baltimore, Maryland 21215-0036

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

MIL St

| | State Registrar Certificate of Death Reg. No. | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|--|
| 0.0 | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pour Year | | | | | | | | | | |
| an cal | John Wayne Ohler | | | | | , 2008 | 3:10 a ^M | | | | |
| er | 4a, Facility Name (If not institution, give street and number) 5716 Tall Timber Lane | | 4b. City, Town, or Location Cascade | | | 4c. County of Death Washington | | | | | |
| | 5. Social Security Number 214-06-9908 6. Sex 1 M 2 □ F 7. As | e (In yrs. last birthday) 37 Yrs. | Months Days Hours | er 24 Hrs. 8. Da 6 Min. NOV | ate of Birth fonth, Day, Yea 23, 19 | 9. Birth Cou Penn | place (State or Foreign ntry) sylvania | | | | |
| | Usual Residence of Decedent 10a. State 10b. County | | 10d. Inside City Limits | | | | | | | | |
| or | Maryland Washington | | 1 ∐Yes 2 K No | | | | | | | | |
| rect | 10e. Street and Number | | 10f. Zip Code | | 10g. (| 10g. Citizen of What Country? | | | | | |
| a D | 5716 Tall Timber Lane | | 217 | '19 | | USA | | | | | |
| ner | 11. Marital Status 12. Was Decedent Armed Forces | Ever in U.S. 13. W | Vas Decedent of Hispanic (Yes, specify Cuban, Mexic | Origin? (Specify Y can, Puerto Rican, | es or No- , etc.) | 14. Race - American Indian, Black, White, etc. | | | | | |
| y Fu | 1 □ Never Married 2 Married 1 □ Yes 2 M If Yes, Give Year or Dates: | No 1 | ☐ Yes 2 No Speci | fy: | | Specify: white | | | | | |
| led k | 15. Decedent's Education | 16a. Deced | ent's Usual Occupation | | 16b. | 16b. Kind of Business/Industry | | | | | |
| Completed by Funeral Director | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or | 27) | kind of work done during m DO NOT use retired) 'ruck Driver | ost of working | | Trucking Co. | | | | | |
| To Be Co | 17. Father's Name (First, Middle, Last) Guy W. Ohler, Jr. | | | ther's Name (First | | Maiden Surname) ller | | | | | |
| F | 19a. Informant's Name/Relationship (Type. Print) Lisa D. Ohler, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5716 Tall Timber Lane, Cascade, MD 21719 | | | | | | | | | | |
| | 20a. Method of Disposition | 20b. Place of Dispos cemetery, crem | sition (Name of natory or other place) | Date | 20c. | Location - City or 7 | ty or Town, State | | | | |
| | 1 X Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | Bethel C | emetery | 8/23/20 | | ascade, M | | | | | |
| | 21. Signature of Funeral Service Licensee | | Name and Address of Fact 10 W. Main S | cility Myer Street, E | rs-Durb mmitsb | oraw Fune ırg, MD 2 | ral Home 1727 | | | | |
| Г | 23a. Part1 Enter the disease, or complications that dause shoek, or heart failure. List only one cause on each i | d the death. Do not ente | er the mode of dying, such | as cardiac or resp | oiratory arrest, | | Approximate Interval Between | | | | |
| | Immediate Cause (Final disease or condition | lung (| erce | | | | Onset and Death | | | | |
| | resulting in death) Due to (or as a consequence of): | | | | | | | | | | |
| e. | Sequentially list conditions, if any, leading to immediate Due to (or as | a consequence of): | | | | | | | | | |
| min | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | | | |
| Medical Examiner | resulting in death) Last Due to (or as | | | | | | | | | | |
| edic | d | | | | | | | | | | |
| Physician/M | | 2 ☐ Fetal death 3 ☐ | Ectopic pregnancy Other (specify) | | | 23d. Date of delivery Month Day Year | | | | | |
| y Ph | Part II. Other significant conditions contributing to death I | course contribute to | ibute to the cause of death? | | | | | | | | |
| ed b | 1/2 Yes 2 No 3 Probably 4 Ui | | | | | | | | | | |
| Completed by | | | | 2 | 24a. Was an autopsy performed | psy prior to completion of cause | | | | | |
| | | | 2□ No | | | | | | | | |
| 25. Was case referred to medical examiner? O 1 Yes 2 No Yes 2 No Yes Ye | | | | | | | | | | | |
| 7: To | 27. Manner of Death 28a. Date of Inj | ury 28b. Time of | . 50 55% | | Describe how in | | ary) | | | | |
| atio | 1 Natural 5 □ Pending (Month, Da 2 □ Accident investigation | | | | | | | | | | |
| ertific | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in building, € | jury - At home, farm, stre tc. <i>(Specify)</i> | eet, factory, office | 28f. L | ocation (Street City or Town, Si | (Street and Number or Rural Route Number, wn, State) | | | | | |
| dical C | 27. Manner of Death 1 | | | | | | | | | | |
| Me | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| ate | 31. Date filed (Month, Day, Year) 32. Regist | rar's Signature | Medical Ca | IMPUS K | (c) Ha | 3 ers 104 | UN WIN X1/4K | | | | |
| rar | AUG 2 2 2008 | rar's Signature | South , | | | | | | | | |
| 2001 | 2000 | | The state of the s | - | | | | | | | |

Regist DHMH 17 Rev 1/200

DHMH 17 Rev 1/2001

State Registrar

AUG 2 8 2008

31. Date filed (Month

Box 68760,

P.0.

Division of Vital Records,

Baltimore, Maryland 21215-0036

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/20/2008 **Physician** PRUETT BEULAH MAS 0310 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) 7/23/1925 7. Age (In vrs. last birthday Funeral Days Hours 1 □ M 2 🔀 F 83 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Exactions must be notified at MD Anne Arundel Odenton 1 □ Yes X No Director 10f. Zip Code 21113 10e. Street and Number 10g. Citizen of What Country? ō 2406 Autumn Harvest Ct. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinations. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White à 1 ☐ Yes 2X No Specify. Specify: 3 XXidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Person 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Miller Otis Chapman ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14453 S.W. 152 P1 Miami, FL 33196 19a. Informant's Name/Relationship (Type. Print) Daughter Jane Boggess 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22/2008 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6283241 VASCUCAR PNY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate Examine if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes 2 No Ippatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 🗆 No 2 Accident I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 739037 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AINE AZUNDEL MEDICAL CENTRZ かいてくれとし MD DOUGLAS 5 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28 Theodore R. Pauley 2008 A^{M} August 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1239 Randalia Rd. Chesapeake City Ceci1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Director 76 234-48-6602 West Virginia 16, 1932 Usual Residence of Decedent filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Cecil Chesapeake City 10e. Street and Number 10g. Citizen of What Country? 1239 Randalia Road Funera 21915 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married XYes 2 Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: 1952-56 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) A traumatic event College (1-4or 5+) Elementary/Secondary (0-12) 5+ Mechanical engineer Engineering permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Perry W. Fauley, Sr. <u>Lula Morgan</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1239 Randalia Rd., Chesapeake City, MD 21915
ce of Disposition (Name of Date 20c. Location - City or Town, State Elizabeth D. Pauley/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 08-30-2008 | Chesapeake City, MD 22. Name and Address of Facility R.T. Foard Funeral Home, F.A.21. Signature of Funeral Service Licenses 318 George St., Chesapeake City, MD 21915 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Khab do myo sarco ma Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be (director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the To the within 29b. Signature and title of certifique 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1VA Khatri, MD 111 W. High St. Ste 104, Elkton, MD 21921 Jamil AUG 2 7 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8,2008 **Physician** ierce Vira ances /Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Talbot Care-Health a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖫 F Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ~ " any injury or other fraumatic event." 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director turlock OYC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Javles 4. Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 █ No þ 3 Widowed 4 Divorced Iack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Process: 1-00d 0 Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Henry ierce 2 Wesley 9b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly St. Hurlock Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 123/08 Cordova, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENKY FUNER 21. Signature of Funeral Service Licenses Funeral MD.21613 510 washington 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 1☐ Yes 2 1 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

P.O. Box 68760. Records, Division or Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

> State Registrar

Medical

31. Date filed (Month, Day, Year AUG 2 Year

determined

4 ☐ Homicide

29b. Signature and title of certifie

29a. Certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert B. Sanchez, M.D. 508 Idlewild Avenue, Easton, MD 21601

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2890 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Vear **Physician** 09 01 2008 1658 JOHN JOSEPH SHERTZER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 MM 2 □ F 11-11-1928 MARYLAND Director 213-24-7212 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ural", or items 23a or 28a-f show 1XYes 2 No Funeral Director ALLEGANY MT. SAVAGE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12804 ST. GEORGE'S LANE NW UNITED STATES 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 1954If Yes, Give 1056 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: WHITE Be Completed by 1956 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TIRE BUILDING MACHINIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 is marked o MARGARET BYRNES SHERTZER JENNINGS SHERTZER ဥ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 ST. GEORGE'S LANE NW MT. SAVAGE, MD 21545 of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other to MARY SHERTZER WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY | 9-4-2008 CUMBERLAND, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 3/ Soures Alan M00547 60 W. MAIN STREET FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Box 68760% Due to (or as a consequence of) Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) P.O. I ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, funeral director, page 2 should be Rheumatord 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death within 24 hours after death

To the Funeral Director: ,

completely filled in by the f 6 ☐ Could not be 3 ☐ SuicIde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier D0055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wulsh RD Cumberland MD 21502 925 Bishop SHIN WUNSOCK 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28902 Reg. No ZUUR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 23, 2008 11:04 PM Arthur SHERMAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 ☑ M 2□ F Pennsylvania 73 176-28-3088 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 ☐ No Maryland Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 5801 Nicholson Lane #716 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sports Memorabilia Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Sherman Ida Levin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 Righter's Mill Road, Narberth, PA 19072 19a. Informant's Name/Relationship (Type. Print) Adam Sherman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Montefiore Cemetery 08/26/08 Abington, PA 4 ☐ Donation 5 ☐ Other (Specify) Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Extensive Cerebellar Infarction with Brain Stem Compression disease or condition resulting in death) Due to (or as a consequence of): Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hypertension 24a. Was an autopsy performed? 1 □Yes 2 🗖 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once.

Directo

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

filed within 72 hours after

Baltimore, Maryland 21215-0036

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Division of Vital

Hospital or Attending

To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the

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/Medical

Examiner Physician/Medical

burial-trar signed by the attending physician be detached for use as the burial icate has been si , page 2 should b Completed funeral director, Be Certification: To After

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1∐Yes 2∭No

27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation

6 Could not be determined 3 Suicide 4 Homicide

28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title

2008

29c. License number D 61264

29d. Date signed (Month, Day, Year August 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Albert Holt IV, M.D., 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) AUG 2 5

State Registrar

Medical



Registrar

AUG 26

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | for State of M. State of M. State of M. Registrar | aryland / Depa <i>Cer</i> | artment of Hear tificate of De | | ental Hyg | Jiene _{leg. No} 2 (| 800 | 28904 |
|---|---|----------------|---|---|---|--|---|---------------------------------|--|--|
| F | Physici | an | 1. Decedent's Name (First, Middle, Last) Edward Malcolm Shenbe | erger | | | 2. Date of Dea Month Aug 24 | th Day | | 3. Time of Death 5:30 P |
| 1 | /Medic Examin | al er | 4a. Facility Name (If not institution, give street and number) 6550 Ben Creek Road | | 4b. City, Town, or Lo | ocation of Death | nug 24 | 4c. Cou | inty of Death | |
| | uneral rector | | | ge (In yrs. last birthday) 68 Yrs, | If Under 1 Year | f Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Aug 22 | | Cou | place (State or Foreign |
| /land | at | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Lo | cation | | | | | 10d. Inside City Limits |
| ле Мап | 8a-f sh otified | Director | Maryland Calvert | St. Leon | | | | 0.00 | -5 \4/14 C | 1 ☐ Yes 2 🖾 No |
| with t | 3a or 2 st be n | | 10e. Street and Number 6550 Ben Creek Road | | 10f. Zip Code 20685 | | | | of What Cou l State | |
| 5-00'36 72 hours after death with the Maryland | ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 ☑ Yes 2 □ 17 Yes 3 □ 17 Yes 3 □ 17 Yes 3 □ 18 Yes 2 □ 19 Yes 19 Yes 2 □ 19 Yes 19 Yes 2 □ 19 Yes 2 □ 19 Yes 2 □ 19 Yes 2 □ 19 Yes 2 □ 19 Yes 3 □ 10 Yes 3 □ 10 Yes 3 □ 11 Never Married 12 Never Nev | Ever in U.S. 13. \No 1963 | Mas Decedent of Hisp f Yes, specify Cuban, l □ Yes 2 No | anic Origin? (Spe Mexican, Puerto Specify: | cify Yes or No- Rican, etc.) | | Race - Ameri Black, White, ecify: | etc. |
| 15-6 | "natur edical | leted | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | dent's Usual Occupation kind of work done dur OO NOT use retired) | on ing most of worki | ng | 16b. Kind o | f Business/Ir | ndustry |
| ZTZTZ zd within /giene. | er than ; the M | Be Completed | Elementary/Secondary (0-12) College (1-4or 12) | | ator | | | | tor/ U | Jnion |
| land 2 | ked oth | To Be (| 17. Father's Name (<i>First, Middle, Last</i>) Ralph Michael Shenberger | | 18 | B. Mother's Name Edna An | (First, Middle, nanda Or | | name) | |
| Mary nd 2 shou alth and N | item 27 is marke other traumatic | | 19a. Informant's Name/Relationship (Type. Print) Maryaline Shenberger -wife | | ng Address (Street and Ben Creek | | | - | | p Code) |
| Saltimore, permit. Pages 1 a Department of Hez | ant: If item ury or othe | | 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | Memorial G | ardens 8 | | Dunki | | own, State Yland |
| Balt permit. Departr | Important: If it any Injury or o | | 21. Signature of Funeral Service Licensee | 44 | 2. Name and Address 05 Broomes | Is. Rd. | Port F | Republ | | 20676 |
| /Me | sician edical miner | X | | d the death. Do not entrine. **Macwa ** a consequence of): | er the mode of dying, | such as cardiac c | or respiratory an | rest, | | Approximate Interval Between Onset and Death |
| recuted | and I-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c. | a consequence of): | | | | | | |
| 58/50, ficate be executed | physician and s the burial-transit | edical E | d | | | | | | | |
| BOX | attending for use a | Physician/Med | | 2 ☐ Fetal death 3 ☐ | Ectopic pregnancy Other (specify) | | | 23d. | Date of deliving Month | very Day Year |
| rdS, P. | been signed by the should be detached | þ | Part II. Other significant conditions contributing to death the Hyperleumon | out not resulting in the u | nderlying cause given | în Part I. | | | contribute to | the cause of death? |
| | scertificate has bee irector, page 2 sho | Completed | | | | | 24a. Was a autop perfor 1 Yes | rmed2 | 4b. Were aut prior to co death? 1 □ Yes | opsy findings available ompletion of cause of 2 ☐ No |
| VIT6 | is certifi director | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpati | ent 2 □ ER/Outpatier | Othor | 26. Place of Death | 1 | | Other (Spec | ify) |
| Ing Phy | Viter th uneral | | 27. Manner of Death 1 Natural 5 Pending (Month, De | | Work? | it : | 28d. Describe h | | | |
| S tea | the | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of in building, e | jury - At home, farm, str tc. (Specify) | | s 2 No | 28f. Location (S City or Tow | | umber or Rui | ral Route Number, |
| he Hospita n 24 hours | To the Funeral Direct completely filled in by | Medical C | 29a. Certifier (Checkonly one) 1 Certifying Physician: To the besi 2 Medical Examiner: On the basis and manner s | of examination and/or in | | | | | | |
| To tl | To t | M | 29b. Signature and title of centifier | | 29c. License r | 8-8 | | 01 | gned (Manth | 8 |
| driv 1 | 0+1 | | 30. Name and address of person who completed cause of RAAR NASR WD 2 | death (Item 23a) (Type, | Print) | × li | isbu M | 100 | 106S | 7 |
| | Sta Registi | | 30. Name and address of person who completed cause of RAK NASR NASR 131. Date filed (Month, Day, Year) 32. Regist AUG 2 6 2008 | ras Signature | Sperlie | | / | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 25^{Day} **Physician** 2008 Phyllis Elaine Stevens /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Nicomico Hospice at the Lako 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2XXF 213-22-5956 Director 79 11/19/1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2 XNo Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5903 Steffee Dr. 21863 USA Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2 👿 No Specify: Specify: 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Office work Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Linwood Doughty Maidie Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy D'Ascoli /daughter 2277 Ridge St., Yorktown Heights, NY 10598 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ortant: If ii Injury or c 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Greenbackville Cem. 8/28/2008 Greenbackville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. □ Tr lb lisease, complications that cluse shock, or he intrailure. Li⊐ only one cause on √ach d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached to 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 □Yes Be 25. Was case referred to medical examines? 26. Place of Death (Check only one) Hospital Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 1 Nopatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27 Manner of Beath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation I Director: A 2 Accident 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral C

イハゾリリュ つ モッピハッ Baltimore, Maryland 21215-0036

WN 12 State

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

AUG 2 6

29d. Date signed (Month, Day, Year)

21802

nd manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ann Marie Swanson 8/21/2008 4:00am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel Date of Birth (Month, Day, Year) 7/20/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 177-01-4353 90 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Experimentation and the profiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 ☐ No Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville RD. 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ⊟Yes 2√3 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽNo White Specify. 2 **3℃**Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook 12 School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Paul Hesso Veronica Gaston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valjean Sanford Daughter 606 TopLand DR. Crownsville, MD 21032 20a. Method of Disposition Department of H
Important: If Iter
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22/2008 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service e Licensee 17 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) geens /Medical Due to (or as a consequence of) Examiner a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed the buriat-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician be detached for use as the buriar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 X No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No cate has been si page 2 should b 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo this certificate 1 ☐ Yes 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ★ Natural 2 ☐ Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tyes 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 004051 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)
Mirza Nusairee, MD 1401 Madison Park Ste 100 Glen Burnie MD 21061 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 2 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician AUGUST Patricia Rose Shymansky /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IVISTA MEDICAL CENTER PLATA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. 1 □ M 2 🖫 F 69 236-56-5154 **Director** 23,1939 January Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director MD Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10586 Deacon Road 20695 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any Injury or other transmitted." College (1-4or 5+) Executive Assistant Air Craft Company Maryland 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) YM ANSK Marlin Rudy Rose Margaret Elizabeth Shrewsbury 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Shymansky/Daughter 10586 Deacon Road, White Plains, MD 20695 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 8/27/08 4 Donation 5 Dother (Specify) Cheltenham, Maryland M0094521. Signature of Funeral Service Licenses 22. Name and Address of Facility FUNERAL HOMEP.A. St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

| Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | b. Ciry/hosic Shull Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): | Coliti |
|--|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions c | contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown |
| | | 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |
| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | | Death (Check only one) |
| 1 Yes 2 No 27, Manner of Death | 28a. Date of Injury 28b. Time of 28c. Injury at | g Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred |
| 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (<i>Month, Day, Year</i>) Injury Work? 1 ☐ Yes 2 ☐ No | zee. Besonde non many decented |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier 1 Certifying Ph | niner: On the best of my knowledge, death occurred at the time, date and planer: On the basis of examination and/or investigation, in my opinion, death o and manner stated. | ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s) |
| 29b. Signature and title of certifier | 29c. License number D 46976 | 29d. Date signed (Month, Day, Year) |
| 30. Name and address of person who | completed cause of death (Item 23a) (Type, Print) | 205 A, Waltof MD 2602 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008

HARLES

WV

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 ☐ Yes 2 No

State

Registrar

Dr Colline P. Sein, 3460 Old Worklyfon

2008

31. Date filed (Month, Day, Year)

AUG 2

| | | | 1 - For State Registrar | | Department of Health and N Certificate of Death | | liene _{eg. No.} 2008 2890 | 8 (|
|----------------|---|------------------|---|---|---|------------------------------|---|---------|
| | 4 | | Decedent's Name (First, Middle, Last) | | | 2. Date of Dea | th 3. Time of Dea | |
| * | Physici | | William J. Sapp | .Tr | | Month Aug. 18 | Day Year 6:42a | M |
| | /Medic | - | 4a. Facility Name (If not institution, give street | | 4b. City, Town, or Location of Death | Aug. 10 | 2008 6:42a 4c. County of Death | |
| | | in the | Carroll Hospital | Center | Westminster | | Carroll | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last bir | thday) If Under 1 Year if Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day | 9. Birthplace (State or For | reign |
| ш | Director | | 212-20-9193 | 82 | Yrs. | July 1, | 1926 MD. | |
| | w | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town | n or Location | | 10d. Inside City Lin | mits |
| | f sho | ō | PA. Adams | Little | stown | | 1 □ Yes 2 |] No |
| | the 28a- | rec | 10e. Street and Number | | 10f. Zip Code | 1 | Og. Citizen of What Country? | |
| | 3a or | Funeral Director | 1264 Fish and Game | Road | 17340 | | USA | |
| | deat | ner | 11 Marital Status 12. 1 | Vas Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- | 14. Race - American Indian, Black, White, etc. | |
| 9 | or ite | /Fu | 1 ☐ Never Married 2☐ Married | GYes 2 No 1944- | 1 ☐ Yes 2 ☐ No Specify: | 7.1041.1, 0.101, | Specify: white | |
| 003 | ural", | d by | 3 ☐ Widowed 4 ☐ Divorced | rear or Dates: 1946 | | | | |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notitled at | Completed | 15. Decedent's Education (Specify only highest grade co | | Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | king | 16b. Kind of Business/Industry | |
| 12 | withir ene. than he M | Ę. | Elementary/Secondary (0-12) | College (1-4or 5+) | nining & Development Manac | er | Black & Decker | |
| | filed Hygi other ent, t | | 17. Father's Name (First, Middle, Last) | | | | Maiden Surname) | |
| lan | ld be lental ked c | To Be | William J. Sapp, Sr | | Helen_Z | ito | | |
| Maryland | d 2 should be filed within h and Mental Hygiene. 7 Is marked other than 'traumatic event, the Me | - | 19a. informant's Name/Relationship (Type. | | . Mailing Address (Street and Number or Ru | | r, City or Town, State, Zip Code) | |
| | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show titem 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at | | Norma Ann Sapp, wife | e 12 | 264 Fish and Game Roa | ad. Litt | lestown. Pa. 17340 | |
| Ore | | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo | 20b. Place of | f Disposition (Name of ry, crematory or other place) | Date | 20c. Location - City or Town, State | |
| Ĕ | Pages ment of I | | 4 □ Donation 5 □ Other (Specify) | Carro | | /2008 | Hampstead, Md. | |
| Baltimore, | permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr | | 21. Signature of Funeral Service Licensee | \$ MO0741 | 22. Name and Address of Facility | line Fun | eral Home | |
| | 00 = 40 | | 23a. Part1. Enter the disease, or complicati | Lemmer | 934 S. Main Street | , Hamps | tead, Md. 21074 | |
| | | | snock, or neart failure. List only one c | ause on each line. | | | Onset and Deat | n th |
| 1 | Physician /Medical | | disease or condition resulting in death) | | ROTIC CORONARY | HRIEF | */ DISEASE | |
| | Examiner | | | Due to (or as a consequence | or): | | | |
| | | e | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence | of): | | | |
| | od d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c | | | | | |
| 0 | be executed ician and burial-transit | Exa | resulting in death) Last | Due to (or as a consequence | of): | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | dical | d | | | | | |
| 9 | entific ling p e as l | Mec | IF FEMALE: | | | | | |
| Вох | leath certific attending p | ian/ | in the past 12 months? | f yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year | r |
| P.O. | the de | Physician/Me | | 9□Unknown | 3 Other (apeciny) | | | |
| | w requires that the de been signed by the should be detached | | Part II. Other significant conditions contrib | uting to death but not resulting i | n the underlying cause given in Part I. | 23e. Did to | bacco use contribute to the cause of death | h? |
| rds | quires n sigr ıld be | d by | | | | 1 🗆 Y | es 2 No 3 Probably 4 Unkr | nown |
| 000 | s bee | Completed | | | | 24a. Was a | | ilable |
| R | The la | mo | | | | autop perfoi | sy prior to completion of cause med? death? 2 □ No 1 2 Yes 2 □ No | e or |
| Vital Records, | siclan: The law certificate has b irector, page 2 s | Be C | 25. Was case referred to medical examiner? | | 26. Place of Dea | | | |
| or V | Physiclan: r this certificatal director, I | To | 1 ☐ Yes 2 No Hosp | Talinpatient 2 ER/OL | | ome 5 Resid | ence 6 Other (Specify) | |
| n | ing P | | 1 Natural 5 ☐ Pending | | Time of 28c. Injury at Work? | 28d. Describe h | ow injury occurred | |
| Sio | ttend Jeath. tor: / | cati | 2 Accident investigation 3 Suicide 6 Could not be | 8e. Place of injury - At home, fa | M 1 Yes 2 No | 28f Location /S | treet and Number or Rural Route Number, | |
| Division | or A after of Direction by | Certification: | 4 ☐ Homicide determined | building, etc. (Specify) | ann, street, lactory, once | City or Ton | n, State) | , |
| _ | To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | S E | 29a. Certifier 1 Certifying Physicia | an: To the best of my knowledge | e, death occurred at the time, date and place | , and due to the | cause(s) and manner as stated. | |
| | e Hos 24 h e Fur | edical | (Check only one) 2 Medical Examiner | On the basis of examination ar and manner stated. | nd/or investigation, in my opinion, death occu | rred at the time, | date and place, and due to the cause(s) | |
| | To th To th comp | Me | 29b. Signature and title of certifier | | 29c. License number | | 29d. Date signed (Month, Day, Year) | |
| | 15+1 | | | 1 4 | - DOO 4436 | , 2 | 08/21/2008 |) |
| | Cew | | 30. Name and address of person who comp | | (Type, Print) 200 MEMORIAL A | 116 | WESTMINSTER | _ |
| | | | | ERUSO, M.D. | 200 MEMORIAL | TUENLE | MD 21157 | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | | | | |
| DH | MH 17 Rev 1/2 | | AUG 2 2 200 | 8 General St. | Good | | | |
| DH | 1/ 1104 1/2 | .501 | | - | ORIGINAL | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-06267

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 2890 State of Maryland / Department of Health and Mental Hygiene Donald Wayne Strouth Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 15, 2008 2350 hrs Medical Examiner Strouth Donald Wayne c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester Berlin Eastbound Route 50 Near Logtown Road If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Min Months Days Hours Maryland 219-19-1679 25 05/03/1983 1 X M Director Yrs 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ıny 10a State 1 Yes 2 X No 28a-f show Salisbury Maryland Wicomico items 23a or 28a-f sho death with the Maryland 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number USA 21801 4401 Smith Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces? 2 Married 1 X Never Married 2 X No Yes Specify: white 1 Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. If Yes. Give Year Divorced nt of Health and Mental Hygiene.

It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. Widowed 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) HVAC Baltimore, MD 21215-0036 worker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Malinda Eugenia Donalds Billy Wayne Strouth Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ٩ 4401 Smith Rd., Salisbury, MD 21801 Billy W. Strouth, Sr/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Roscoe Jones (Allen) 1 X Burial 2 Cremation 3 Removal from State 8/21/08 Allen, MD Cemetery Donation 5 Other Specify: 22. Name, and Address of Facility Holloway Funeral Home Professional Association ignature of Funeral Service Licensee 24 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Donamore Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Day Year Month 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 2 use as Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Įo. 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ş Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? has 1 🗸 Yes 2 ✓ Yes 2 No page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Division of Vital Other₄ Hospital: Residence 6 Other: Scene examiner? Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Passenger auto fixed object collision Certification: Aug 15, 2008 2340 hrs Yes 2 ✔ No Natural Pending within 24 hours after death. To the Funeral Director: Director: d in by the f 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Eastbound Route 50 Near Logtown Road, , MD 3 Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 17, 2008 O.C.M.E. Myonte SA 30. Name and a dress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD.

strar's Signature 32. Re 31. Date filed (Mont ADG Yeg) 2 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18 2008 12:10A M August Larry Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 50 Greystone Ct. Apt D Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day SCOT 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 6. Sex 5. Social Security Number **Funeral** Year 948 Min. Months Days Hours Maryland 1**7** M 2□ F 59 Yrs. 217-52-2547 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Extrainer must be notified at ¥ Yes 2 No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 50 Greystone Ct. Apt D Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 □Yes 2【□No Specify: Specify: Black <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 t n College (1-4or 5+) Truck Driver City of Annapolis 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Sellman William Thomas Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau once. 50 Greystone Ct. Apt D Annapolis, Md. 21403 Elsie J. Thomas(Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Hope UM Church 8-23-08 Edgewater, Md. 4 ☐ Donation 5 ☐ Other (Specify) Williame Resse of AciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ongestu disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 Yes 2 No NIA 1 □Yes 2 ■No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 € 100 Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

137 Mitchells Chance Rd, Edgewater MD21037

29d. Date signed (Month, Day, Year)

Funeral Director r than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at Baltimore, Maryland 21215-0036 t and 2 should be filed within Health and Mental Hygiene. is marked other Pages 1 and 2 should permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau
once. **Physician** /Medical

Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:20 am 2008 Carolyne Hilda Tucker August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Civista a Plata Charles 8. Date of Birth (Month, Day, Year)
April 26,1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 □ M 2 🖾 F Days Months Hours Min. Yrs. 389-18-4879 88 WI Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7931 Wheatly Road 20646 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: White Completed by Specify: 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Wolf Lorraine Pagnae ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forrest Tucker/Son 7931 Wheatly Road, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gar: 8/23/2008 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FUNERAL HOME, P.A. any 211 St. Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Examiner Neun Sequentially list conditions, if any, leading to infilinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? has certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **∑**No 1 → patient 2 □ ER/Outpatient 3 □ DOA this Certification: To After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 192008 0 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mellon Patel 102 Suite 107 Waldorf MD 20607 Paul MD Court 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 0 2000 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8-22-08 **Physician** Lisa Tipton 15:00p M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Ctr. Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🖵 F 222-44-6195 51 7-4-1957 Delaware Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "sedical Exercity activity by rediffied at 1 ☐ Yes 2X No Director Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 USA 4032 Abingin Drive Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ∐Yes 21 No Black, White, etc. 1 Never Married 2 Married White 1 ☐Yes 2XNo Specify: If Yes, Give Year or Dates: Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Computer Consultant Chemical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Kenneth C. Pierce Pauline Wright ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eddie A. Tipton / Husband |4032 Abingin Drive, Abingdon, Maryland 21009 Health item 27 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Oak Lawn Cemetery 8-28-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Beeson Funeral Home Of Newark
2053 Pulaski Highway, Newark, 21. Signature of Funeral Service Licens CC0442 DE 19702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** letastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 WNo 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a ipton, Usa M800490 Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 □Yes 2 □No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 No death. Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by within 24 hours after To the Funeral Direct 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

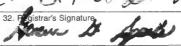
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr. Bel Muhammand Jokhad 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 2008 Twilley В. Norris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SAlisbury Kegional Medical Center Wicomico If Under 1 Year | # Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6-17-1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Maryland 85 357-14-8390 **Director** Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County death with the Marylan 10a State 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Evanther must be notified at 1 ☐ Yes 2X No Funeral Director Delmar MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21875 USA 10015 Norris Twilley Road 12. Was Decedent Ever in U.S Armed Forces? 1 Q 4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1945-72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1947 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) A 27 Is marked other than "r traumatic event" 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Director of Agricultural Sales Utilities 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Beach Clyde Twilley May Owens ပ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra once. Mary Emily Twilley - Wife 10015 Norris Twilley Road, Delmar, Maryland 21875 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8-22-2008 Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Lice Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? ditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has tirector, page 2 s autopsy performed? 1 □ Yes 2 □No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🔲 Homicide 24 hours after e Funeral Dire detely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical To the Hosp within 24 ho To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

find

State Registrar Date filed (Month, Day Year) 5 2008

who completed cause of



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 Helen Elizabeth Timmerman Hugurt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 218-20-9651 27, Director 80 Dec. 1927 Maryland Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Director Dorchester Cambridge No Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 USA Funeral or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married □Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 2 Specify: white 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 should be filed w h and Mental Hygier 7 is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Roane ပ Marjorie unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i 26164 Miles River Rd., Easton, MD 21601 George R. Ingersoll Jr. Baltimore, son20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Salisbury Crematory 8/23/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate
Interval Between
Onset and Death
I A HOUG Immediate Cause (Final **Physician** numonia ration ロン disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ending physician use as the burlal Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. ed by the detached 1 ☐ Yes 2 No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an has e 2 s autopsy page this certificate 2 XNo 1 Yes or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural death. neral Director; / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after To the Hospital o within 24 hours af To the Funeral Di completely filled in **Exertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State

Registrar

29b. Signature and title of certifie

William

31. Date filed (Month

100

strar's Signature

Framble St. Cambridge,

and manner

30. Name and address of person who completed cause of death (Item 23a) (Type Pint)

25

stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AYLOR 2008 LMA kuks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL HOSPICE UNIT RANDALSTOWN, BALTIMORE COUNTY Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours 79 122-22-0483 Director APR 06,1929 SYRACUSE, NY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at DELAWARE SUSSEX COUNTY **DAGSBORO** 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 29915 MOUNTAIN LAUREL DRIVE 19939 or items 23a UNITED STATES filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced "natural" Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF NURSING HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EARL J. CONWAY 2 FRANCES PRAME 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZAN LAPPS (DAUGHTER) 2800 RIDGE RD., BALTIMORE, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of He
Important: If iten
any Injury or oth 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State DELAWARE VETERANS CEM SEP 04,2008 MILLSBORO, DELAWARE 22. Name and Address of Facility WATSON FUNERAL HOME P.O. BOX 125 MILLSBORO, DE MO 1361 23a. Part1. Enter the disease or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a pach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumoni disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial Box 68760 attending physician for use as the buris Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a P.O. 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign I be 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy page 1 Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death of Injury 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the ft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ò Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ZOCE e and address of person who completed cause of death (Item 23a) (Type, Print) M Gro L -0 31. Date filed (Month, Day, Year) egistrar's Signature State 2008 SEP 09 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

2. Date of Death

ral", or items 23a or 28a-f show Examiner must be notified at

Funeral

Director

/Medical Examiner

within 24 hours a

Month Day **Physician** 4:40 P M 2008 Minna Work August 20, Fricke /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Kensington Montgomery Park Kensington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 X F 98 Tennessee April 7,1910 545-12-7514 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TyrYes 2 □ No Director Kensington Montgomery Md. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20895 USA #108 3620 Littledale Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White ò 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School High School Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minna Marie Dreyer Charles John Fricke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22101 Charles R. Work - son 1621 Maddux Lane McLean, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 22 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 21. Signature of Fulleral Service Lice 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 KULL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Coronary Artery Disease Years Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2∑ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 Yes 2 No 1 □ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0030484 August 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles A. Umosella, M.D. 7625 Wisconsin Ave., Bethesda, Md. 20814 31. Date filed (Month, Day, Year) 32-Registrar's Signature State AUG 25 Registrar 2008

08-06468

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 28917

| chaer Keith vv | 1 F | For State Certificate of Death Reg. No. 13 Time of Death |
|--|----------------|--|
| Physicia | ın/ | I. Decedent's Name (First, Middle,Last) |
| edical Exami | | Michael Keith WILSON, Sr. August 23, 2006 |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County or Death 4d. County o |
| E | | E Sevial Security Number 16 Sex 7 Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MWDD/YYYY) 9. Birthplace (State or |
| Funeral Director | | 106-58-9679 1X M 2 F 44 Yrs. Months Days Hours Min. June 2, 1964 CountryNew York |
| any | - | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits |
| <u>*</u> | . | 1 Yes 2 X No |
| rylanc a-f sh | 용 | Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? |
| rith the Maryland s 23a or 28a-f show a | Director | 11822 Peacock Trail 21742 USA |
| with the second | ┏ | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- |
| death with the Maryland or items 23a or 28a-f sh must be notified at once | Funeral | Never Married 2 X Married 1 Yes 2 X No Black |
| after al", o | by F | 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 A No specify: Specify: |
| 215-0036 be filed within 72 hours after natal Hygiene. rked other than "natural", cent, the Medical Examiner i | Pe | 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) |
| 136 hin 72 e. than " | ompleted | Police Officer Private Convrity |
| 5-003 iled withi Hygiene. I other th | E | 11 0 POLICE OFFICER PRIVATE SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |
| 21215-0036 Uld be filed within 7 Mental Hygiene marked other than | BeC | Moses Wilson Ann Grant |
| 2 a a a a a a | To | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev | | Julia Wilson - Wife 11822 Peacock Trail, Hagerstown, Md. 21742 20a Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State |
| re, s l and f Hea If iten | | 20a. Method of Disposition Removal from State Removal from State |
| caltimore, mit. Pages I ai epartment of He portant: If ite | | 4 Donation 5 Other Specify: Hagerstown Crematory 8/27/08 Hagerstown, Maryland |
| Baltil Bermit. Departm Importa | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home |
| Acres to the latest th | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and |
| Physician // dical | | failure. List only one cause on each line. |
| kaminer | | Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of): |
| | | Sequentially list conditions, b. |
| | ner | if any, leading to immediate Due to (or as a consequence of): |
| | Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): |
| cuted ind transit | <u>~</u> | d |
| e exec cian a rial - 1 | Medical | UNPENDED AMENDED |
| 760, cate be ex physician the burial | J. | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live high 2 Fetal death 3 Ectopic pregnancy Month Day Year |
| 68 certifi nding | ician/ | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Fetal death 3 Ectopic pregnancy Month Day Fetal death 5 Other (Specify) |
| Box 687 E death certific the attending p | 1 10 | 1 Yes 2 No 9 Unknown 9 Unknown |
| D.O. Box 687 that the death certifical ned by the attending p detached for use as the | / Phys | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| , P.O. ires that the signed by | d by | |
| rds requires | ete | autopsy prior to completion of cause of |
| eco he lav nte has | Completed | performed? death? 1 🗸 Yes 2 No 1 📝 Yes 2 No |
| Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death. at Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach. | BeC | 25. Was case referred to medical 26.Place of Death (Check only one) |
| Vits nysicia Ithis ce I direc | B | examiner? 1 ✓ Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 ✓ Other: Scene |
| of ing Pl | ١٣ | 27. Manner of Death 28a. Date of Injury (Month Day Year) 1 Natural 5 Pending Aug 23, 230 hrs 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot |
| ttendi ttendi death. | atic | 2 Assidant Investigation |
| Division pital or Att cours after ducaral Direct filled in by | Certification: | 3 Suicide 6 Could not be or Town, State) |
| Spital hours neral | S | 4 Momicide |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi | ical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) |
| To t with To t | Medical | and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) |
| | | O.C.M.E. August 24, 2008 |
| | | 30. Name and address of person who completed cause of death (Item 23a) |
| 5H-5 | | Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |
| | State | 31. Date filed (Month, Day, Year) 32. Roistrar's Signature |
| Regi | stra | |
| DHMH 17 Rev 1 | /2001 | OCME ORIGINAL |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20 Day Physician 2008 Ouise 6:20 AM Aug /Medical 4c. County of Death 4b. City, Town, of Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Talbot Genesis HealthCare The Pines Easton 8. Date of Birth (Month, Day, Year)
April 391917 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 🖫 F 15'8-16-8811 Usual Residence of Decedent maryland Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Talbot ON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ane 21601 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 2 **P**No 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Bernice Walley allinois altimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Garment Industry Seamstress 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Easton, MD.21601 Lane James 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery 8/26/08 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23a. Frtt. Enter the disease, or complications that caused the orath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Cause (Final) hapatic metastases Immediate Cause (Final years Physician disease or condition resulting in death) /Medical Examiner 5 squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Winsing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUTCHMAN'S LANG

State Registrar 31. Date filed (Month. Day

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MD

(ROWLLY

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Time of Death Day **Physician** Donald Isaac Wheatley 16 505 PM 08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMIC PENINSULA REGIONAL MEDIENL 542186414 8. Date of Birth (Month, Day, May 15, If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days 77 Maryland 217-28-2673 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Exam, incrinust be rufflied at once. 10a. State 1 XYes 2 □ No Directo Maryland Wicomico Sharptown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 800 Fourth Street 21861 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1951-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ No Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 X No 1955 Specify ģ Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David L. Wheatley Emma Mae Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Walker/Daughter P. O. Box 445, Sharptown, MD 21861 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Sharptown Firemens Cem. 8/26/2008 | Sharptown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22.Name and Address of Facility eller Funeral Home, P. O. Box 207 06 Main Street, East New Market, MD 21631 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASCVD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Parkinson's DISTASE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transii Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 WNo this certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parbulal Day, 106 Hulfma 37. ## 504B. Salisbury . MD 21804 Das, 106 Hilford 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ruby Ware 15, 2008 3:40 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico 1086 McGrath Road Eden If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/28/1927 5 Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 81 Maryland Director 218-20-5528 Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evanings must be notified at 1 ☐ Yes 2 No Director Wicomico Eden Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or items 23a or? 21822 1086 McGrath Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ∐Yes 2 🔀 No Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tyes 2 XNo Specify. Completed by 3 Nidowed 4 Divorced white 7 Is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) beautician beauty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Molly M. Phillips Clayton Townsend ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1086 McGrath Rd., Eden, MD 21822 Star Richardson/daughter item 27 other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Wicomico Memorial Department o Important: If i any Injury or once. ± 5 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/20/08 Salisbury, MD 4 Donation 5 Dother (Specify) Park 21. Signature of Fun ral Service Licens 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the due th. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consecu Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only within 2. and manner stated. the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2

State

Registrar

31. Date filed (Month, Day,

AUG 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Day ELSA WERTENBAKER September 1, 2008 1:04 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-26-1922 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 214-28-7492 86 Germany Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Dunford Court 21793 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21X No 2 Specify: Specify: 3 → Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Geographic permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Foreign Register 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Valentin Roeder Anna Baumbach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Holdcroft 2638 Point of Rocks Rd Knoxville, MD 21758 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem 9-5-2008 Frederick, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Keeney & Basford P.A. F.H. M01176 106 East Church St. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy ō in the past 12 months? Yea Day 4☐Pregnant at time of death 5 Other (specify) ed by the a Division or Vital Records, P.O. 9□Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an . Were autopsy findings available prior to completion of cause of page 2 s certificate has performe Yes autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

27. Manner of Death 5 Pending investigation

2 Accident 6 Could not be determined 3☐ Suicide 4 Homicide

SEP 0

2 ☐ ER/Outpatient 3□ DOA Inpatient 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

examiner

1 Natural

1 ☐ Yes 2 No

29b. Signature and title of certifier

Be

၉

Certification:

Medical

After this

in 24 hours after user the Funeral Director; A'

2

Hospital or Attending

the the McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

21707

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MD51610

MD

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Whalley Clementine /Medical 09 08 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND
If Under 1 Year | If Under 24 Hrs. ALLEGANY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec 1, 1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months Μ̈́D 217-42-6731 Director 93 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinet must be notified at MD Allegany 1√Yes 2□No Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with an and Mental Hygiene.

is marked other than "natural", or items 23a or 13512 Poppy Street 21502 USA Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ XNo Specify. ₽ Specify: 3 X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Crabtree Tracey (Thomas) Crabtree ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. 13512 Poppy Street V. Dawn Brant Cumberland MD 21502 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery 9/4/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licen 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final diseas or condition resulting in death) DISFASE **Physician** KONAR 10 400 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last-Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit law requires that the death certificate be execu Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No certificate 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title

Wamar

of certifier

Zaman

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

904 Seton

Registrar's Signature

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Suite 203, Cumberland, MA 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 8:10 A M LOUIS **BERNARD** ANDERSON SEPTEMBER 8, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 T F Director FEB 24, 1917 OH 297-01-6215 Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 No 2 □ No Director MD PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 LEISURE DRIVE 20748 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕅 No Specify. Specify: þ 3 ₩ Widowed 4 □ Divorced BLACK Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC POLICE DEPT POLICE OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES ROSEMOND ANDERSON LELIA H. WEAVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE ANDERSON / SON 724 BARNWELL AVENUE NE AIKEN, SC 29801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 09-30-2008 SUITLAND, MD of Funeral Service Licensee 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1 Enter the disease of shock, or heart failure. List for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pronury CLYTER Due to (or as a conseque of): /Medical Examiner pothermi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Box 68760, requires that the death certificate be executed burief-transi Due to (or as a consequence of) and physicien s the buriel Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 **7** % 3 Probably 4 Unknown 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy he eb-d certificate 1 ☐ Yes 2 ☑ No 2 No 1 □ Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division ospital or Attending hours after death. 5 ☐ Pending investigation 1 Natural 2 Accident Injury within 24 hours arten occ...
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2008 D0052999 zanulay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive G-06 CLINTON 10403 RAHIMI MD 31. Date filed (Month, Day, Year) 32. egistrar's Signature

Registrar

2008

Section of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) eptember 6, 2008 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner HUSDI saltimore General If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
 Country) 5. Social Security Number 214-68-56 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Months Min 1 □ M 2 🔀 F IRGINI 2 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Modical Event is at most be notified at any Injury or other traumatic event, it a Modical Event is at most be notified at any Injury or other traumatic event. 1 Yes 2 No HIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 2121 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. ☐Never Married 2☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 2 No 1 Yes Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) aintinance Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20a. Method of Disposition
1 🗆 Burial 2 🖸 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility f Funeral Service Lie romartie Scrvice · Balto-MD 2122 Approximate Interval Between Onset and Death 23a Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause o _each line. Immediate Cause (Final Due to Fras a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner gari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐Yes 2 ☐ No of Vital 1 □Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1☑Yes 2☐No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 ∏ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jaryland 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 10

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

er than "natura , the Medical E

other

. Pages 1 and 2 should be fill tment of Health and Mental H tant; If item 27 Is marked oth t of Health and Ments If item 27 Is marked or other traumatic ev

Department of Important: If it any Injury or or

filed within 72 hours after death

Maryland 21215-0036

altimore,

Director

Completed by Funeral

MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending abundance of the contribution of the co attending physician and for use as the burial-tran

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be Certification: To

filled in by

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year IS AM **Physician** Booker 09 06 Larence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown COC Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**□**¶ 2□ F Director Mary land Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director MD saltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number an "natural", or items 23a or Medical Examiner must be 21215 Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 0. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic content. the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd 9923 King Itimore, tamela aguant <u>inden</u> MU 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Jurial 2 Cremation 3 Removal from State 12/2008 Baltimore, Mi 4 □ Donation 5 □ Other (Specify) Cemeter 22. Name and Address of Facility Howell Approprie of Funeral Service License Funeral Home 0 4600 Baltima, MD 24207 Liberty Honts 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE PULMONARY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 performed certificate 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident hours after death Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, Hospital or Attending within 24 hours a To the Funeral L the

law requires that the death certificate be executed

Box 68760

P.0.

Maryland 21215-0036

Baltimore,

State Registrar

LEDNARD RICHARDSON 31. Date filed (Month, Day, Year) SEP 1 0 2008

29b. Signature and title of certifie

1838 32. Registrar's Signature

MO 30. Nam a dress of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year) SEPTEMBER 8 2008

GREEN TREE RUAP \$ 300 PIKES VILLE MO

29c. License number

DS7722

| 2008 | 2 | 8 | 9 | 2 | |
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|------|---|---|---|---|--|

| | | | 1 - State Registrar | | | Certificate of | Death | | Reg. No | 200 | 8 2 | .892 |
|---------------------|--|-------------------|--|---|--------------------------|--|-------------------------------|---|------------------------|------------------------------------|----------------------------|------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, La | | | | | 2. Date of D | Da | ay Year | - 0 . | ne of Death |
| | /Medic | | Barbara Ann | Billings | | | | 327En | | 28.200 | 2 | 431 M |
| | Examin | er | 4a. Facility Name (If not institution, give | CHTNGTON | MEN | 4b. City, Town, c | CI & | 0 2 | | County of Dea | Av. | HORI |
| | Funeral | _ | 5. Social Security Number 6. S | Sex 7. Age (/ | n yrs. last birt | | If Under 2 | 4 Hrs. 8. Date of B | irth | | rthplace (St | ate or Foreign |
| | Director | | 213 10 7700 | ¹ □ ^M ² X ^F 59 | | Yrs. Months Days | Hours | Min. (Month, L) $July 2$ | | 949 | ountry) MI | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | 10 | oc. City, Town | or Location | | | | | 10d Insid | le City Limits |
| | Maryla f sho | ļo | MD Anne Art | | Glen B | | | | | | | Yes 2 No |
| | r 28a | irec | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Ci | tizen of What C | | |
| | th with | Funeral Director | 925 Nabbs Creek I | Road | | 21060 | | | US | A | | |
| | r dea | nuel | 11. Marital Status | 12. Was Decedent Eve Armed Forces? | r in U.S. | 13. Was Decedent of H | lispanic Orig an, Mexican, | in? (Specify Yes or N Puerto Rican, etc.) | 0- | 14. Race - Am Black, Whi | | n, |
| 36 | be filed within 72 hours after death with the Maryland nat Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Eventre naut terreaffied at | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced | 1 □Yes 2 → No If Yes, Give X Year or Dates: | | 1 □ Yes 2 No | Specify: | | | Specify: W | | |
| 21215-003 | 2 hou latura ical E | ted | 15. Decedent's Ed | ducation | 16a. | Decedent's Usual Occup | oation | | 16b. K | (ind of Business | /Industry | |
| 215 | thin 7 ne. nan "n | Completed | (Specify only highest gra | College (1-4or 5+) | | (Give kind of work done life. DO NOT use retire | d) | | COL | mnutora | | |
| | filed wi Hygier Sther the | Co | 12 | | С | omputer tec | | | | mputers | | |
| anc | | Be c | 17. Father's Name (First, Middle, Last, Seymour Gertz |) | | | | 's Name <i>(First, Middl</i> llis Brads | | i Surname) | | |
| ar Z | 2 should I and Men is marke | ᅀ | 19a. Informant's Name/Relationship (| Type. Print) | 19b. | Mailing Address (Street | | | | or Town, State. | Zip Code) | |
| ž. | es 1 and 2 should of Health and Mer f Item 27 is marke r other traumatic | | Phyllis Gienski (| (mother) | | 04 Strawbri | | | | | | 34 |
| ore | | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Domount from State | 20b. Place of cemeter | Disposition (Name of y, crematory or other place | ce) | Date | 20c. L | ocation - City or | Town, Stat | 9 |
| Ĕ | Pages tment of tant: If its jury or o | | 4 Donation 5 Other (Specif | | Wesley | Freedom Ce | 1 | -12-08 | - | esville | • | |
| Baltimore, Maryland | permit. Page Department of Important: If any injury or | | 21. Signature of Funeral Service Licer Page Haight | | | P.O. Box 1 | | Haight Furesville, | | | & Chap | e1 |
| | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only | plications that caused the | e death. Do n | ot enter the mode of dyi | ng, such as c | cardiac or respiratory | arrest, | | Approx | imate Between |
| 4 | Physician | | Immediate Cause (Final disease or condition | | WET | MIA | | | | | Onset a | and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a co | onsequence o | | . 0 1 | - 21- | ~ | 4 | | |
| | | <u>r</u> | Sequentially list conditions, | b. Due to (or as a co | onsequence o | | 1177 | TA TO | 47 | | | |
| | ansit ansit | Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | ,,,,,, | ,, | | | | | | |
| Ď, | e exec | | resulting in death) Last | Due to (or as a co | onsequence o | f): | | | | | | |
| P8/P0 | e law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit | Medical | | d | | | | | | | | |
| Ď X | certific | | IF FEMALE: | 23c If was outcome of r | regnancy | | | | | | | |
| 0 | atten for us | Physician | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim | J Fetal death | 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _ | :у | | | 23d. Date of de Month | elivery Day | Year |
| Ċ. | t the c by the ached | hysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9 Unknown | | | | | | | | |
| , L | gned pe det | by P | Part II. Other significant conditions of | ontributing to death but n | ot resulting in | the underlying cause giv | en in Part I. | 23e. Did | tobacco | use contribute t | the cause | of death? |
| ecoras, | een si | ted | | | | | | 1□ | Yes 2 | .□ No 3□ F | robably 4 | Unknown |
| Lec | has b | Completed | | | | | | 24a. Wa | DDSV . | prior to | completion | ngs available of cause of |
| <u></u> | The licate r, pag | | | | | | | per 1 □ Yes | ormed? 2 ☑ No | death? 1 □ Ye | s 2□No | |
| VII | siciar certif rectol | Be | 25. Was case referred to medical examiner? | Hospital: | | national SEE DOA Oth | or: | of Death (Check only | | | | |
| 5 | y Phy er this eral d | Ę, | 1 ☐ Yes 2 ☑ No 27. Man or of Death | 28a. Date of Injury | 28b. T | ime of 28c. Injul | 4 ⊔ Nur | sing Home 5 Res | | | ecify) | |
| SION | ath. r: Affe | atio | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day, Ye | ear) In | | k? Yes 2⊡N | | | | | |
| <u> </u> | r Atte | Certification: To | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - building, etc. (5 | At home, fari | m, street, factory, office | | 28f. Location City or To | (Street ar | nd Number or R | lural Route | Number, |
| 2 | pital o | | 20- Confidence Al-Constitution Bi | | | | | | | | | |
| | 24 ho 24 ho Fune etely 1 | Medical | 29a. Certifier 1 ✓ Certifying Ph (Check only 2 ☐ Medical Exar | nysician: To the best of m niner: On the basis of ex- and manner stated | amination and | death occurred at the tide of the didentification of the didentifica | me, date and ppinion, deat | d place, and due to the h occurred at the time | e cause(s , date an | s) and manner a d place, and du | as stated. e to the cau | se(s) |
| | To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Luneral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u | Me | 29b. Signature and title of certifier | and married states | | 29c. Licens | e number | | _29d. Da | ate signed (Mon | th, Day, Yea | ir) |
| b | | | Fred | 7 | N | D E | 345 | 149 | sen | teuber | 8 | 2008 |
| | 6 | 1 | 38. Name and addless of person who | com leted cause of death | (Item,23a) (| Type, Print) | | el | a | | | 2008 20161 |
| | Stat | , Q | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signatura | Piral a | rive | yeer | MC | rrue 1 | YU | 00101 |
| | ~ ~ ~ ~ ~ ~ | - | o Date med (Mortal, Day, Teal) | oz. megistiar s | oliginatyire | I MANGERY S. | | i 1 | | | | |

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - State Registrar | State of Ma | ıı yıarı | • | | e of Dea | | • | Reg. No. | 08, | 2892{ |
|---------------------|---|----------------|---|--|-----------------|--------------------------------|----------------------------|---|-----------------------------|--|---|--|--|
| | Physici /Medio | | 1. Decedent's Name (First, Middle, L Ralph A. Brown | ast) | | | | | | Month SEPT. | | oar 08 | 1610 M |
| 1 | Examin | | 4a. Facility Name (If not institution, g | | F3h) | CM C | 4b. City, | Town, or Locat | ion of Death | | 4c. County of | Death | |
| | Funeral Director | | | Sex 7. Age | | ast birthday) Yrs. | If Under Months | 1 Year If Un Days Hou | nder 24 Hrs. urs Min. | 8. Date of Birl (Month, Da Aug 27, | Mic th y, Year) 1923 | 9. Birthpla Counti | ace (State or Foreign ry) W. VA. |
| | land Dw | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | 100 | d. Inside City Limits |
| | a-f sh | ctor | MD Somerset | | Wes | tover | | | | | | | 1 □Yes 2□No |
| | /ith the | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | 10g. Citizen of Wh | at Countr | y? |
| | eath v | Funeral | 6239 Crickett Hill F | 12, Was Decedent E | ver in U.S | 3. 13. | Was Deced | 21871 lent of Hispanic | c Origin? (Sr | pecify Yes or No | | SA America | n Indian |
| 36 | 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modeal Examiner must be realified at | by Fun | 1 ☐ Never Married 2/12 Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: | 943 | - | if Yes, spec 1 □ Yes 2 | | | pecify Yes or No Pican, etc.) | Black, | White, et | c. |
| 21215-0036 | 72 hou 'natura cheel E | eted | 15. Decedent's I (Specify only highest g | Education | | 16a. Dece | dent's Usua kind of wor | al Occupation rk done during i | most of work | ina | 16b. Kind of Busi | | |
| 121 | within liene. than " | Completed | Elementary/Secondary (0-12) | College (1-4or 5- | -) | | <i>DO NOT us</i> right | e retired) | | | Kavanaugh | Rende | ering Co. |
| nd | e filed al Hyg d other went, | BeC | 17. Father's Name (First, Middle, Las | t) | | | | 18. M | lother's Nam | e (First, Middle, | Maiden Surname, |) | |
| Baltimore, Maryland | d 2 should b th and Ment 7 is marked traumatic e | 2 | Albert Brown | (T. D.) II | | | | | essie F | | | | |
| B ≥ | 25 ± 2 | | 19a. Informant's Name/Relationship Emma L. Gabbert-Brow | | | 1 | _ | | | stover, MC | er, City or Town, S) | tate, Zıp (| Code) |
| J.e. | ges 1 and it of Healt if item 2 or other | | 20a. Method of Disposition | | 20b. Pl | lace of Dispo | | | T . | Date | 20c. Location - C | ity or Tow | n, State |
| <u>H</u> | permit. Pages Department of Important: If it any injury or o | , | 1&X*Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | | Ba1 | Di more I | | | | 15, 2008 | Baltimore | , MD | - |
| Ba | permir Depar Impor any ir | | 21. Signar (ed) Funeral Service Lo K. Gregory Fink | M0114 | 8 | 22 | Fink | d Address of Fa Funeral Crain Hwy | Home, F | P.A. Ten Burnie | , MD 2106 | 1 | |
| | | | 23a. Part 1 Enter the disease, or conshock or heart failure. List on | pplications that caused one cause on each line | the death e. | | | | h as cardiac | or respiratory ar | rrest, | | Approximate Interval Between Onset and Death |
| inde E | Physician /Medical | ï | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as a | consequ | | Infa | ret | | | | _ | |
| | Examiner | | Sequentially list conditions | b | | | | | | | | | |
| | nsit A | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a | consequ | ence of): | | | | | | - 1 | |
| oʻ | an and rial-tra | Exar | that initiated events resulting in death) Last | cDue to (or as a | consequ | ence of): | | | | | | | |
| 68760, | rtificate be executed on physician and as the burial-transit | ledical | • | d | | | | | | | | | |
| . Box | eath certi attending for use a | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown | 2 ☐ Feta! | death 3 | Ectopic pr Other (sp | | | | 23d. Date Mont | | y Day Year |
| л О | hat the ed by th letach | Phy | 9 Unknown Part II. Other significant conditions | | not resu | Iting in the ur | ndarhina es | use diven in P | art I | 23e Did tr | obacco use contrib | ute to the | cause of death? |
| Hecords, | w requires that the do been signed by the should be detached | ò | CHF | contributing to death bu | | iting in the th | idenying ca | duse given in Fa | ant 1. | - 1 | | | bly 4 ☐ dnknown |
| ပ္မ | 6 8 6 | Completed | | | | | | | | 24a. Was autop perfor 1 □ Yes | rmed? de | ere autopo or to com ath? Yes 2 | sy findings available pletion of cause of 2 □ No |
| Vital | ician: certific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Othor: | | h (Check only o | ne) | | |
| <u></u> | y Phys er this eral dir | ٤ | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injur | / | ER/Outpatien 28b. Time of | | 8c. Injury at | Nursing Ho | | dence 6 Other | | |
| VISION | ending sath. or: Afte he fune | ation | 1 Natural 5 Pending 2 Accident investigation | | Year) | Injury | М | Work? 1 ∐Yes 2 | 2 □ No | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Certification: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined | building, etc. | (Specify | ") | | | | City or Tow | | | |
| | e Hospi 24 hou e Funer letely fill | Medical | 29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa | hysician: To the best o miner: On the basis of and manner stat | examinat | vledge, death ion and/or in | n occurred vestigation, | at the time, dat in my opinion, | te and place death occur | , and due to the rred at the time, | cause(s) and man date and place, an | ner as sta d due to t | ited. the cause(s) |
| i | Within To the comp | Me | 29b. Signature and title of certiller | | | | | . License numb | | | 29d. Date signed | Month, D | ay, Year) |
| | | 1 | | | | | - | 00053 | 3394 | | 9-8- | 08 | |
| | 17 | | 30. Name and address of person who | | _ | 23a) (Type, I | 100 | E.C. | 21101 | 11st | Salisbu | ryh | mDd1801 |
| | Sta Begistr | | 31. Date filed (Month, Day, Year) | 32. Registra | | | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2,3 per me, g883,09722/08amb and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 09/03/2008 1. Decedent's Name (First, Middle, Last) Month Day **Physician** ALVINNA BOUKNIGHT /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number Examiner clinton yar, la Sout Lern Mace corgeis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Days Months Hours Min 1 □ M 2X F DC JULY 22, 1953 Director 577-76-1733 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modes | Evan instrument be motified at 1X Yes 2 □ No Director DC WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with USA 20019 1022 47TH PLACE NE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 X Never Married 2 ☐ Married 2 X No 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced **BLACK** Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. DC PUBLIC SCHOOLS TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental F Be ROSETTA FLOYD RICHARD BOUKNIGHT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 i LYNETTE NICHOLS / DAUGHTER 1022 47TH PLACE, NE WASHINGTON, DC 20019 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09-13-2008 LAUREL, MD MARYLAND NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) MARSHALL'S FUNERAL HOME OF MD 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility SUITLAND, MD 20746 4308 SUITLAND ROAD DONALD R. GRAY 23a. Pan . Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final roba **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Die to (or as a nonsequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): ing physician a P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð rence 1 | Yes 2 | No 3 | Probably 4 | Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ANO Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA ၉ 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

SEP

29c. License number

29d, Date signed (Month, Day, Year)

and manner stated

3001

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** THOMAS HOWARD BUTLER SEPTEMBER 2008 2210 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F **Director** MARCH 3, 1943 577-56-7383 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MDPRINCE GEORGE'S CAPITOL HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. or Items 23a or Funeral 6909 DRY LOG STREET 20743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No 1 ☐ Yes 2 🛛 No Specify 2 Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MVO FOREMAN FEDERAL GOVERNMENT 10th is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ဂ္ BESSIE REBECCA WEEMS JOSEPH HENRY BUTLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau CAPITOL HEIGHTS, MD SARAH MINERVA BUTLER / WIFE 6909 DRY LOG STREET 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 09-13-2008 CLINTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. P. 11 En er the disexed, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 10 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 052815 2008 an 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL ALEXANDER 3001 HOSPITAL DRIVE CHEVERLY, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

| | | | For State Registrar | amend | State of N #30 Per DV | /arylan R G88 : | d / Depa 3 9/10 | rtmen 708 J <i>tilicat</i> | t of H H e of L | ealth Death | and M | lental Hy | giene Reg. Na | 2008 | 3 | 28931 |
|--|--|----------------|--|---------------------------------------|---|---------------------------------------|---------------------------------|---|--------------------------------------|---|-------------------------|---------------------------------|--|----------------------------|--------------------|--|
| | | | 1. Decedent's Name | | | | | | | | | 2. Date of De Month | | | ar | 3. Time of Death |
| | Physici /Medio | | | a Beaup | | | | | | | | August | 27, | 2008 | | 11:45 AM |
| | Examir | ner | • | | give street and numbe | er) | | | | Location | of Death | | | County of E | | •• |
| A POPE | _ | | 5. Social Security Nu | an Hosp: | | Ane (In vrs | last birthday) | If Under | theso | 1a If Under | 24 Hrs. | 8. Date of Bir (Month, Da | | ont go | | y lace (State or Foreig |
| | Funeral Director | | 037-24-20 | | 1□ M 2∏ F | 71 | Yrs. | Months | Days | Hours | Min. | (Month, Da Aug 21 | y, Year) • 19 | | Coun | e Island |
| | 5 | | Usual Residence of | Decedent | | | | | | | | | | | | |
| | show | <u>~</u> | 10a. State | 10b. County | | | y, Town or Lo | | | | | | | | 10 | 0d. Inside City Limits 1 □Yes 2√⊋No |
| | 28a-f | Director | MD 10e. Street and Num | Montgo | omery | В | ethesd | .a. 10f. Zip | Codo | | | | 10a Citi | zen of Wha | Coun | |
| 7 | a or | Ξ | 5721 Gro | | Lane | | | 101. 210 | Code | 208 | 14 | | rog. On | USA | | .,. |
| | ges I and z should be lifed within 7 z hours arier death with the maryand it of Health and Mental Hygiene. It of Health and Mental Hygiene. I fee Z7 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinal must be notified at | Funeral | 11. Marital Status | | 12. Was Deceder Armed Forces | ? | S. 13. | Was Deced If Yes, spec | dent of Hi cify Cuba | spanic Or n, Mexica | igin? (Sp n, Puerto | ecify Yes or No Rican, etc.) |)- | 14. Race - A Black, V | Americ /hite, e | an Indian, etc. |
| Maryland 21215-0036 | ural", or | by | 1 ☐ Never Marrie | 4 Divorced | If Yes, Give Year or Dates | | | 1 □Yes | - | Specify. | : | | 100 (4) | Specify: | | |
| ָה ק | "nat | Completed | (Speci | 15. Decedent's ify only highest | grade completed) | | 16a. Dece | dent's Usua kind of wo DO NOT us | al Occup: rk done c se retired | ation <i>luring mos</i> | st of work | ing | 16b. Ki | nd of Busin | ess/Inc | lustry |
| 7 | iene. | E O | Elementary/Secor | ndary (0-12) | College (1-4o | r 5+) | ,,,,, | | sab1e | | | | | none | | |
| ם פר | other other /ent, | Be C | 17. Father's Name (| First, Middle, La | ast) | | | | | | er's Name | e (First, Middle | , Maiden | Surname) | | |
| 9 | Menta Menta arked | 일 | Lawson H | I. Wheel | ler | | | | | Веа | tric | e Eliza | beth | Brod | eur | |
| Z Z | alth and 27 is may rtaums | | 19a. Informant's Na Martha Va | | | | 1 | - | | | | al Route Numb Provid | | | | |
| saitimore, | rages I a nent of Hea int: If item iry or othe | | 20a. Method of Disp 1 Burial 2 4 Donation | Cremation 3 | □Removal from State | ie | Place of Dispo emetery, crei | sition (Nar natory or o | ne of ther plac | e) | I | Date | 20c. Lo | cation - City | or To | wn, State |
| Dal | Department of Important: If any Injury or once. | | | | censee Di | | 1 | Name ar | | - | | 655 W. | . Bal | timor | e S | treet |
| | hysician and busician and the private transit the private transit the private transit the private transit the private transit the private transit the private transit the private transit the private transit the private transit tran | dical Examiner | Immediat. Cause (idisease or condition resulting in death) Sequentially list con if any, leading to immediate. Either Under Cause (Disease or that initiated events resulting in death) L | Final ditions, nediate lying | b. Due to (or a | | uence of): | arte | ry d | isea | se | | | | | Onset and Death |
| To Some and the state of the st | | Physician/Medi | IF FEMALE: 23b. Was decedent in the past 12 I 1 □ Yes 2 □ 9 □ Unknown | months? | 23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknowr | n 2 ☐ Feta t at time of d | I death 3 | ∃Ectopic p ∃Other <i>(sp</i> | | 4 | | | | 23d. Date o Month | f delive | ery Day Year |
| . (5.3. | s been signed by t | | | | s contributing to death | | _ | | _ | en in Part | l. | | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊡ Onknow | | | |
| VIII II II COILES, | rate has bee page 2 shou | Completed by | tachycardia | | | | | | | 24a. Was auto perfo | | | opsy prior to completion of cause of death? | | | |
| 3 | certificate rector, pag | BeC | 25. Was case referr | ed to medical | | | | | | 26. Plac | e of Deat | 1 ☐ Yes h (Check only | 2 🗓 Nr6 one) | | 162 | 2 □ No |
| or vita | S in | 일 | examiner? 1 ☐ Yes 2 ☐ | No | Hospital: 1 1 mpa | atient 2 🗌 | ER/Outpatie | nt 3□DC | Oth | ^{er:} 4□N | ursing Ho | ome 5 ☐ Res | idence | 6 □Other (| Specif | y) |
| - 3 | offer the | E | 27. Manner of Death | 5 Pending | 28a. Date of It (Month, I | njury D <i>ay, Year)</i> | 28b. Time o Injury | | 8c. Injur Work | | | 28d. Describe | how injur | y occurred | | |
| | fler death. iirector: A n by the fu | Certification: | 2 Accident 3 Suicide 4 Homicide | investiga 6 ☐ Could no determin | t be 28e. Place of I | Injury - At ho etc. <i>(Specif</i> | ome, farm, str y) | M eet, factory | | Yes 2 □ No 28f. Location (Street and Number or Rural Route Number Of Rural Route Nu | | | | i Route Number, | | |
| ָהַ נָּי [ָ] | within 24 hours after death. To the Funeral Director; After the completely filled in by the funeral | Medical Cer | 29a. Certifier (Check only one) | 1 Certifying 2 Medical E | Physician: To the be xaminer: On the basis and manner | s of examina | wledge, deat | h occurred | at the tir | ne, date a plnion, de | ind place, ath occur | and due to the | e cause(s , date and |) and mann d place, and | er as s | stated. the cause(s) |
| 4 | within 2 the comple | Mec | 29b. Signature and | title of vertifier | and manner | oraidu. | - | 290 | c. License | e number | | | 29d. Da | te signed (A | fonth, | Day, Year) |
| , i | - ≯ ⊢ ŏ | | 1 | N | 1 | | | | | 0117 | | | | | | 9/08 |
| • | | | | · | ho completed cause o | , | , , , , , | Print) | | |)() p | ockvill | ا ما | | | |
| | -01 | | Eric Jo 31. Date filed (Mont | oon—Shil h. Dav. Year) | | | | | KD S | re of | O K | lockvil1 | Le ,r | IQ. 20 | U)4 | |
| | Sta Registr | | | 1 0 200 | 8 100 | 1 | ture | 20 | | | | | | | | |

8/2:7/08 1145AM

BEAUPRE

BARBARA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28932 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 12:45 PM August Noray Luree Blackwell /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Shady Grove Hospital Rockville 8. Date of Birth (Month, Day, Yea Jan. 31, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🔀 F Maryland 1933 Director 213-30-1471 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1∩a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hadical Evarities roust be notified at 1 ☐ Yes 2 No Director Montgomery Village Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with 20886 USA 19310 Clubhouse Road Apt. 522 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: White 9 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Secular 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Viola Brady James Richard Sanders ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 19221 Autumn Maple Lane, Gaithersburg, MD 20879 Department of Health Important: If item 27 any Injury or other troone. James Blackwell / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1. Surial 2 Cremation 3 Removal from State 4 Donation 5 □ Ofne (Specify) Cokesbury U.M.C. Cem. 9-6-08 Abingdon, Maryland 21 Signature 7 Figure 50 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part I. Enter the diseas shock, or heart failure. e, or complications that caused the List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence o): MOS. disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical pronary IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à icate has been si, page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a Was an autopsy certificate 1⊠Yes 2□No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📉 No 1 ☐ Yes 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral e Hospital or Attending Pl 24 hours after death. Funeral Director; After the telety filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

completely

To the I within 2

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Suhair Abulfarag,

0

ORIGINAL

and manner stated.

32 Registrar's Signature

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

M.D.

604 S. Frederick Ave. #413, Gaithersburg, MD 20877

29d. Date signed (Month, Day, Year)

2008

| | 1 - For State Registrar | State of Marylan | | rtment of H | | | giene 008 | 28933 |
|--|---|---|------------------|---|-------------------------|--|--|--|
| Physician | 1. Decedent's Name (First, Middle, Last | | | | | 2. Date of Dea Month | ath Day Year | 3. Time of Death |
| /Medical | GEORGE C. I | BIEGGERMAN, | | | | Septer | nber 8 20 | |
| Examiner | 4a. Facility Name (If not institution, give | street and number) | 1 | 4b. City, Town, or | | ath | 4c. County of Dea | ith |
| | 5. Social Security Number 6. Se | x 17. Age (In yrs. | last histogram | If Under 1 Year | If Under 24 H | rs. 8. Date of Birt | N/A | theless (Chate on Consider |
| Funeral Director | 215-18-3395 | SM 2□F 85 | | Months Days | Hours Mi | n. (Month, Day | , 1923 M | rthplace (State or Foreign ountry) ARYLAND |
| ₩ | Usual Residence of Decedent | - 05 | | | | <u> </u> | , 1925 FIF | MIDAND |
| ylan | 10a. State 10b. County | 10c. Cit | y, Town or Loc | ation | | | | 10d. Inside City Limits |
| Sa-fs Ma | MD N/A | Ba | Itimo | ore | | | | 1 Yes 2 □ No |
| or 26 | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What C | ountry? |
| officer death with the Maryland rifems 23a or 28a-1 show rifeer must be mutilized at Funeral Director | 914 S. POTOMAC | STREET | | | 1224 | | U.S.A | ۷. |
| tems to ma | 11. Marital Status | 12. Was Decedent Ever in U. Armed Forces? | S. 13. W | as Decedent of His Yes, specify Cubar | spanic Origin? | (Specify Yes or No- erto Rican, etc.) | 14. Race - Am Black, Whi | |
| 036 urs after all, or I | | 1 ☐ Yes 2 XNo If Yes, Give | 1 [| ☐Yes 2X No | Specify: | | Specify: | |
| 5-0036 72 hours after natural, or ite | 15. Decedent's Edu | Year or Dates: | 16a Decede | int's Usual Occupa | tion | | 16b. Kind of Business | ITE |
| 215. ithin 72 Nan 'na Madic | (Specify only highest grad | e completed) | (Give k | ind of work done di O NOT use retired) | uring most of w | rorking | TOD. KIND OF BUSINESS | silidustry |
| 21215-00 led within 72 has ygiene. ner then "natura is, the Medical E | Elementary/Secondary (0-12) | College (1-4or 5+) | L | ABORER | | | CONTINENT | 'AL CAN CO. |
| be filed that do other event, be | | | | | 18. Mother's N | ame (First, Middle, | Maiden Sumame) | |
| Viand be wental arked o atto eve | GEORGE C. BI | EGGERMAN, S | R. | | MARY | FOERTS | CHBECK | |
| Maryland to 2 should be file th and Mental Hy to 1 is marked oth traumatic event To Be (| 19a. Informant's Name/Relationship (T) | | 19b. Mailing | Address (Street a. | nd Number or I | Rural Route Numbe | r, City or Town, State, | Zip Code) |
| ss 1 and 2 of Heelth of Heelth of Heelth of them 27 i | MARIE FOERTSCHE | | | | | , ANNAND | ALE, VIRGI | NIA 22003 |
| Pages 1 nent of H int: If Her iry or oth | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F | | | tion (Name of atory or other place | | Date | 20c. Location - City of | |
| Fact: Part: | 4 Donation 5 Other (Specify) | SAC | RED HE | EART OF | JESUS | 9/11/0 | 8 BALTIMO | RE, MARYLAN |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. To Recompleted by Funeral Director To Re Completed by Funeral Director | 21. Signature of Fund Pervice Licens | 66 | 22 [1] | Name and Address | S of Facility ZEILER | INC. FU | UNERAL HO ALTIMORE, | ME |
| 40360 | Mulle | Joseph ! | 19 | OT EAST | L'ERN A | VENUE, B | <u>_</u> | |
| #ya | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | ne cause on each line. | n. Do not enter | the mode of dying | j, such as cardi | ac or respiratory ar | rest, | Approximate Interval Between Onset and Death |
| Physician | Immediate Cause (Final disease or condition resulting in death) | Sop | 212 | | | | | Onsor and Dodin |
| /Medical Examiner | | Due to (or as a consequ | uence of): | | | | | |
| | Sequentially list conditions, | Due to (or as a consequ | ence of): | | | | | |
| mln sit | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury | | | | | | | |
| executed exact in and rial-transit | that initiated events resulting in death) Last | Due to (or as a consequ | ence of): | | | | | |
| I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examin | | d | | | | | | |
| P.O. Box 6876/ nat the death certificate be d by the attending physicie letached for use as the bur Physician/Medical | | | | | | | | |
| Box 68 leath certifica attending ph for use as it | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregna 1□Live birth 2□Fetal | | ctopic pregnancy | | | 23d. Date of de | elivery |
| o deal | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4 Pregnant at time of de | | Other (specify) | | | Month | Day Year |
| that the de detached is detached if | 9 Unknown | | | | | | | |
| IS, F | Partil. Other significant conditions co. | tributing to death but not resu | ating in the und | lerlying cause give | n in Part I. | | bacco use contribute t | |
| Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be completed by | | | | | | · ' ' | 'es 2 □ No 3 □ P | robably 4 Unknown |
| Relaw has the person | | | | | | 24a. Was autop | sv prior to | utopsy findings available completion of cause of |
| | | | | | | perfor | med? death? 2) No 1 Ye | s 2 🗆 No |
| Of Vita Physician: this certificeral director. To Be C | 25. Was case referred to medical examiner? | lospital: | | Other | r | eath (Check only o | | |
| Physical chiral control of the contr | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury | 28b. Time of | 3LI DOA | 4 🗆 Nursing | 1 | lence 6 Other (Speciow injury occurred | ecify) |
| Attending Rate. death. ector: After by the funer. | 1 Matural 5 Pending investigation | (Month, Day Year) | Injury | 28c. Injury Work' M 1 □ Y | ? es 2 □ No | | | |
| Division I or Attending after death. Director: Afte Jin by the fune ertification | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At ho | me, farm, stree | et, factory, office | | | Street and Number or R | Pural Route Number, |
| in a star in a s | 4 Homicide | building, etc. (Specify | ') | | | City or Tow | n, State) | |
| | 29a. Certifier (Check only 2 Medical Exami | sician: To the best of my know | wledge, death o | occurred at the time | e, date and pla | ce, and due to the | ause(s) and manner a | s stated. |
| the Hosp thin 24 hou the Fune impletely fil | one) | ner: On the basis of examinat and manner stated. | ion and/or inve | stigation, in my opi | inion, death oc | curred at the time, o | date and place, and du | e to the cause(s) |
| To the complet | 29b. Signature and title of certifier | nher is | 900 | 29c. License | number | | 29d. Date signed (Mon | th, Day, Year) |
| | P(| J. 10, | , - , | N007 | 9140 | ۷ (| epter | - 0,000 |
| 3 | 30. Name and address of person who co | mpleted cause of death (Item | 23a) (Type, Pr | rint) | | 1 0 | \ | |
| | 31. Date filed (Month, Day, Year) | 32. Registrar's Signat | SI LO | ch Kan | en Bl | nd. Bal | do, mo | 11, Day, Year) 21,239 |
| State Registrar | SEP 1 0 2008 | Brent K | don't | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28934 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death SEPTEMBER 7 2008 ear **Physician** BLATTBERG BERNICE R 9:58A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3021 FALLSTAFF ROAD, #606 BALTIMORE 8. Date of Birth (Month Car) 1921 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 👿 F 88 NΥ 215-24-1600 Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items on any injury or other traumatic 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 3021 FALLSTAFF ROAD, #606 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐Yes 2 XNo Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEALER ANTIQUES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GREENBERG LITT TILLIE SAMUEL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3021 FALLSTAFF ROAD, #606, BALTIMORE, MD LEO BLATTBERG / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE CEM. 09/09/2008 BALTIMORE, MD 4 Donation 5 Dother (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Onar /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con-Physician/Medical phys the b IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 IINo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Physician: The law requires that the death certificate be executed Box 68760. P.0. of Vital Records. or Attending

> State Registrar

completely

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

1 🚣 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** SEPTEMBER 1, JOY BOSTON 3:15a^M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A FUTURECARE LOCHERN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Yrs Director <u>214–</u>68–0499 45 11-15-1962 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho Director 1 XYes 2 □ No MDN/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Exercises 2008. 3327 WINTERBOURNE RD. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ∏XNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-INTERNAL REVENUE CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM D. BOSTON, JR SYLVIA GENTT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERREL BOSTON-SMITH(SON) 3327 WINTERBOURNE RD. BALTIMORE, MARYLAND 21216 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation ∕3 □ Removal from State WOODLAWN CEMETERY 9-5-2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 Other Specify) HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Sign ware c 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as e correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans クレイ Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.O. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4/3 Gommonueatter AL 31. Date filed (Month, Day, Year) State Registrar SEP 10 2008

Certificate of Death

2. Date of Death

3. Time of Death

2:30 P M

Birthplace (State or Foreign Country)

Black

Month

-10-08

Year

10d. Inside City Limits

1 Nes 2 No

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

AWADALL

32. Registrar's Signature

MAL

10

31. Date filed (Month, Day,

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

以

State

Registrar

08-06870 Flavia D'Cunha Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 28937

| | | 1- For State Registrar_ | | Cer | tificate of | Death | | | Reg. No. | | | |
|--|------------------|--|--|--|-----------------------------|---------------------|---------------------------|--------------------|----------------------------------|------------------|---|--|
| Physicia | | 1. Decedent's Name (First, Middle | t's Name (First, Middle,Last) 2. Date of Death | | | | | | | | | |
| Medical Exami | ner | FLAVIA D | PLAVIA D'CUNHA September 8, 2008 | | | | | | | | | |
| M*- | | 4a. Facility Name (if not institution | n, give street and | number) | 4 | b. City, Town, or | Location of D | | | County of Dea | ath | |
| | | Cedar Creek Ln & Fai | rland Rd | | | Silver Sprin | | | Me | ontgomery | | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. Ia | ast birthday) | If Under 1 Yea | r If Under 24 | 4Hrs. 8. Date | of Birth (MM/D | D/YYYY) 9. E | Birthplace (State or | |
| Director | | 695-09-5940 | | | | Months Day | | Adin | 23/1978 | Fore | eign | |
| | | | 1 M 2 X X | 29 | Yrs. | | | 12/ | 23/19/0 | , | Country) India | |
| any | | Usual Residence of Decedent 10a. State 10b. County | | Inc. City | Town or Location |)D | | | | | 10d. Inside City Limits | |
| . ≥ | | | | | | | | | | | 1 X Yes 2 No | |
| faryland 28a-f show 1 at once. | ō | VA Henr | 100 | GT | en Alle | | | | | | | |
| Mary 28a- d at | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citize | en of What Co | ountry? | |
| 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once. | | 10909 Virginia | Forest | Court | | 23060 | | | Ind | lia | | |
| with ms 2. | Funeral | 11. Marital Status | | ecedent Ever in U. | | Decedent of Hi | | | | | erican Indian, Black, | |
| death r ite | Š | 1 Never Married 2 Married 2 | arried Armed | Forces? | If Ye | s, specify Cuba | n, Mexican, Pu | ierto Rican, et | | White, etc. | | |
| fler | by F | 3 Widowed 4 X Div | orced If Yes, Give Y | | 1 | Yes 2 X No | specify: | | s | specify: Ind | lian/Asian | |
| 5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner | a l | 15. Decedent's Education (Spec | | rade completed) | | s Usual Dccupa | | | 16b. Kir | nd of Business | s/Industry | |
| 72 ho | Completed | Elementary/Secondary (0-12) | College | (1-4 or 5+) | during mo | st of working life | . DO NOT use | e retired) | | | | |
| thin thin thin thin thin | ם | | 4 | years | Compu | ter Prog | grammer | | Sc | Software Company | | |
| 5-0036 lled within Hygiene. I other tha | 8 | 17. Father's Name (First, Middle, | Last) | , - | | ľ | 18.Mother's N | lame (First, Mi | ddle, Maiden S | Jurname) | | |
| | B | Elias D'Cunha | | | | _ | Pressy | Pinto | | | | |
| 2121 2121 July be fi Mental marked ic event, | 2 | 19a. Informant's Name/Relations | hip (Type, Print) | | 19b. Mailing | Address (Stree | | | | or Town, Sta | ite, Zip Code) | |
| MD d 2 sho lith and n 27 is | | Arun D'Cunha | / brot | her | 10909 | Virgin | ia Fore | st Ct. | Glen A | Allen, | VA 23060 | |
| ore, ME | | 20a. Method of Disposition | | | Place of Disposit | ion (Name of ce | | Date | | | or Town, State | |
| imore, MD 2 Pages 1 and 2 shoument of Health and I lant: If item 27 is ror or other traumarie | | 1 Burial 2 Cremation | 3 XXRemoval | | rematory or othe John tl | 00/17/ | 0/17/08 Bombay, India | | | | | |
| timen rtamt | | 4 Donation 5 Other Sp | | | | | | | Home, P.A. | | | |
| Baltimore, permit. Pages 1 at Department of Her Important: If ite | | 21. Signature of Funeral Service | Licensee | / M00770 | 101 | | | | | | | |
| | _ | 45 >4r | | · | | 3 Talbot | | | | | | |
| Physician /Medical | | 23a. Part I. Enter the disease or failure. List only one cause | | t caused the death. | . Do not enter the | e mode of dying | such as cardi | ac or respirate | ory arrest, shoc | k, or heart | Approximate Interval Between Onset and | |
| xaminer | ı | Immediate Cause (Final disease | a. Multiple I | njuries | | | | | | | Death | |
| | | or condition resulting in death) | Due to (or as | | | | | | | | | |
| | ايرا | Sequentially list conditions, | b | | | | | | | | _ | |
| | ١ <u>ڦ</u> | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as | a consequence of | 1): | | | | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequence of | f): | | | | | | | |
| executed an and all - transi | | | d | | | | | | | | | |
| | n/Medical | UNPENDED | AMENDE |) | | | | | | | | |
| 8760, ifficate be ng physici as the buri | ě | IF FEMALE: | 23c. If yes | s, outcome of pregr | nancy | | | | 23d. | Date of delive | erv | |
| | a l | 23b. Was decedent pregnant in the past 12 months? | | e birth | 2 Feta | al death 3 | Ectopic pre | egnancy | | Month | Day Year | |
| Box (e death ce the attence ed for use | iż. | 1 Yes 2 No 9 V Unk | nous I | gnant at time of de | ath 5 Oth | er (Specify) | | | - 3 | | (4) | |
| | Physicia | | 3 0118 | nown | | | | | | | | |
| P.O. | P. | Part II. Other significant conditi | ons contributing | to death but not re | esulting in the ur | iderlying cause | given in Part I. | | | | to the cause of death? | |
| 0) OD U | 힣 | | | | | | | _ [1] | Yes 2 🗸 | No 3 Pr | obably 4 Unknown | |
| rd: | ompleted | | | | | | | 24a. | Was an autopsy | | autopsy findings available completion of cause of | |
| e lav | 틹 | | | | | | | _ | performed? | death? | ? _ | |
| of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si | ပ | 25. Was case referred to medical | | | | 26 Place | of Death (Ch | | Yes 2 No | 1 🗸 | Yes 2 No | |
| ital | a | examiner? | Hospital: | Inpatient 2 | ER/Outpatient | | Othor | ursing Home | 5 Desides | ce 6 🗸 Oth | | |
| FV Phys | 리 | 1 Yes 2 No 27. Manner of Death | ' | | 28b. Time of In | Language Company | ry at Work? | | cribe how injur | | ner: Scene | |
| n of ding Ph. | 崩 | 1 Natural 5 Pend | Sep 8 | te of Injury nth, Day Year) , 2008 | 0746 hrs | ' ' ' ' | ryatworki Yes 2. ✔ No. | Dodoo | strian struck | by vehicle | e | |
| isior Attend r death rector: | ا ق ا | | tigation | | | | | | | | | |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a supple of the funeral director, page 2 should be a supple of the funeral director, page 2 should be a supple of the funeral director, page 2 should be a supple of the funeral director, page 2 should be a supple of the funeral director. | ertification: | | not be | ace of Injury - At ho | | , factory, office I | building, etc. | 28f. Loca or To | ation (Street and own, State) | d Number or F | Rural Route Number, City | |
| Divi | Ö | 4 Homicide | mined (Specif |) Local Stree | et | | | Cedar C | reek Ln & Fa | irland Rd, S | ilver Spring, MD | |
| e Ho 124 b e Fur letely | | | | est of my knowledg | | | | | | | | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director, | Medical | one) 2 Medical Exam | and manner | s of examination ar stated. | ng/or investigatio | on, in my opinior | i, death occurr | red at the time | , date and place | e, and due to | the cause(s) | |
| | Ž | 29b. Signature and title of certifie | | |) | 29c. Licens | e number | | 29d. Da | ate signed (M | fonth, Day, Year) | |
| | | KOTE. | 11000 | i | CODE. | O.C. | M.E. | | Septe | ember 9, 2 | 8008 | |
| | - } | 30. Name and address of person | who completed ca | use of death (Item | 23a) | ۸] | | | | | | |
| 5 | | Patricia Aronica-Pollak | | stant Medical E | | 111 Penn S | reet, Baltin | nore, MD 2 | 21201 | | | |
| St | ate | 31. Date filed (Month, Day, Year) | | Registrar's Signatu | te A. | D. D | | | | | | |
| Regist | | 31. Date filed (Month, Day, Year) SEP 1 0 2008 32. Registrar's Signature | | | | | | | | | | |

| | | | For Amend #5,17,1 | State of Ma | gyland/E | epadi Certif | ment of H | ealth a Death | and M | ental Hy | /giene Reg. No | 9009 | 28938 |
|------------|--|------------------|--|--|---------------------------------|--|--|------------------|-------------|-------------------------------|-------------------|-----------------------------|--|
| Ŋ. | | _ | Decedent's Name (First, Middle, Last | | | | | | | 2. Date of D Month | | C 0 0 0 | 3. Time of Death |
| е | Physici: /Medic | | Joanne D' | Amico | | | | | | Sept. | | y Year 2008 | 9:40 A M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b | c. City, Town, or | Location o | of Death | | 4c | . County of Dea | ath |
| | | | 6405 Kenhowe Driv | | | | Betheso | | 2411 | | | Montgom | |
| | Funeral | | 5. Social Security Number 6. Se 176-34-6068 | x 7.Age ⊒M 2.531.F | (In yrs. last birt | | Under 1 Year onths Days | If Under a | Min. | 8. Date of Bi (Month, D | lay, Year) | C | rthplace (State or Foreign ountry) |
| | Director | | T69-34-6068 Usual Residence of Decedent | | 65 | 113. | | | | larch | 23,19 | 943 Peni | nsylvania |
| | land ow at | | 10a. State 10b. County | | 10c. City, Town | or Location | on | | | | | | 10d. Inside City Limits |
| | Mary Fied | ţċ | Maryland Montgom | erv | Bethes | da | | | | | | | 1 ☐ Yes 2 🛛 No |
| | r 28a | irec | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Cit | tizen of What C | ountry? |
| | th wit | a D | 6405 Kenhowe Driv | e | | | 20817 | | | | Į | JSA | |
| | ems er mu | Funeral Director | 11. Marital Status | 12. Was Decedent E Armed Forces? | ever in U.S. | 13. Was | Decedent of His | spanic Orig | gin? (Spe | cify Yes or N Rican, etc.) | 0- | 14. Race - Am Black, Whi | |
| 98 | or it | | 1 ☐ Never Married 2 ☑ Married | 1 ☐ Yes 2 X N If Yes, Give | lo | | Yes 2 X No | | | | | Crooks | |
| 8 | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show ideal Examiner must be notified at | d by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | 162 | Docadant | 's Usual Occupa | otion | | | 16h K | W I and of Business | hite |
| 15- | - " 0 | lete | 15. Decedent's Edu (Specify only highest grad | le completed) | | (Give kind | d of work done d NOT use retired | luring mosi) | t of workir | ng | 100. K | and or business | 5/IIIdustry |
| 21215-0036 | within iene. than "the Mec | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | ⁺⁾ L | | t Editor | | | | Pι | ıblishi | ng |
| 0 | be filed within 72 hours after death with the Marylar ttal Hygiene. dd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Be C | 17. Father's Name (First, Middle, Last) | | | — I . | | 18. Mothe | er's Name | (First, Middl | e, Maider | n Surname) | |
| lan | Ald be fental rked o | To B | Joseph Mornelli | Morinelli | | | | Anna | Gras | si | | | |
| Maryland | s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M | | 19a. Informant's Name/Relationship (7 | vpe. Print) | 19b. | . Mailing A | ddress (Street a | and Numbe | er or Rura | l Route Num | ber, City | or Town, State, | Zip Code) |
| Σ, | ロモアヤ | | Anthony J. D'Amic | o/ Son | | | enhowe D | rive | | | 4 | yland 2 | |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once. | | 20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ | Removal from State | 20b. Place of Function | Disposition of the Company of the Co | on (Name of ory or other place O 1C ES OI | <u>e</u>) ! | D | ate | 20c. L | ocation - City o | r Town, State |
| Ë | ment ment tant: jury | | 4 Donation 5 Other (Specify |) | Chanti | 11y | | - ! | 9/10 | | | | y, Virginia _ |
| 3al | permit Depar Impor any in once. | | 21. Signature of Funeval Barrice Licens | | | | ame and Addres | | OTC | | | eral Cho | |
| | | | Maril Rell | 4 | 00968 | | | | | | | ndria, N | VA 22307 |
| Į, | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | one cause on each lin | the death. Do r | ioi enter tr | ne mode or dying | g, such as | cardiac o | r respiratory | arrest, | | Approximate Interval Between Onset and Death |
| d | Physician / /Medical | | Immediate Cause (Final disease or condition resulting in death) | | Tempor | | ementia | | | | | | 5 Years |
| | Examiner | | | Due to (or as a | a consequence o | of): | | | | | | | |
| | | <u>.</u> | Sequentially list conditions, | b Due to (or as a | a consequence of | of): | | | | | | | |
| اد | nusit | i i | Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events | | · | | | | | | | | |
| 9 | exect n and ial-tra | Examiner | resulting in death) Last | c Due to (or as | a consequence o | of): | | | | | | | |
| ₹709Z8 | death certificate be executed e attending physician and of for use as the burial-transit | ical | | d | | | | | | | | | |
| 9 | rtifica ng ph as th | | 2555445 | | | | | | | | | | |
| Вох | leath certific attending pl | an/N | 23b. was decedent pregnant | 23c. If yes, outcome 1 ☐ Live birth | pf pregnancy 2 □ Fetal death | 3□Ec | topic pregnancy | | | | 1 | 23d. Date of de | |
| | ed fo | sici | in the past 12 months? 1 ☐ Yes 2 🖾 No | 4□Pregnant at 9□Unknown | | | ther (specify) | | | | | Month | Day Year |
| P.0 | requires that the de een signed by the a hould be detached t | Physician/Med | 9 ☐ Unknown Part II. Other significant conditions co | | it not requilting in | thounda | rhuin a course aire | n in Bort I | | 220 Did | Ltobacco | uco contributo | to the cause of death? |
| JS, | w requires that s been signed to should be det | by | rattii. Other significant conditions co | onthibuting to death bu | at not resulting in | i tile ulluei | nying cause give | mmraiti | | | | | Probably 4 ☐Unknown |
| Records, | requ been | Completed | | | | | | | | | | | |
| 3ec | e la has | ld m | | | | | | | | 24a. Wa aut | opsy | prior to | autopsy findings available completion of cause of |
| a | ician; The I certificate ha ector, page ; | | or W | | | | | | | | -7 | o 1 ☐ Ye | |
| or Vital | | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No | Hospital: | nt 2 ☐ ER/Ou | trationt | 3 DOA Othe | | | (Check only | | 6 □Other (Sp | 16 1 |
| o | | H-1 | 27. Manner of Death | 28a. Date of Injur | ry 28b. 1 | Time of | 28c. Injury Work | 4 LI NU | | 28d. Describe | | | есіту) |
| Division | Attending Phrdeath. ector: After the by the funeral | ig | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | (Year) I | njury | | <br Yes 2□ | No | | | | |
| Visi | Atter | iţi | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of inju | ury - At home, fa | rm, street, | factory, office | | 2 | | (Street a | | Rural Route Number, |
| Ö | i di di | Certification: | | Junuing, etc | . (Opolity) | | | | | July 01 1 | viii, Oldi | ~/ | |
| | Hospital 14 hours a Funeral I tely filled | | | sician: To the best of the basis of | | | | | | | | | |
| | To the H within 24 To the F complete | Medical | one) | and manner sta | | | | | | | | | |
| | 7 with 6 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 con 7 c | 2 | 29b. Signature and title of certifier | 1 | | | 29c. License | | | | | ate signed (Mo | |
| | 1 | | quiser | 1 non | arm | رلاد | MD 3 | 2156 | | | Sep | tember | 5, 2008 |
| | 15 | | 30. Name and address of person who | | | | | t 7 • • • • | | | D.C | 0016 | |
| | Sta | ate | Kristin Thomas, M 31. Date filed (Month, Day, Year) | | New Mex ar's Signature | X1CO | Ave., N | w, Wa | shin | gton, | DC 2 | 0016 | |
| | Regist | | SEP 1 0 2008 | Maren | Nº An | will | | | | | | | |

DHMH 17 Rev 1/2001

X

State

Registrar

30. Name and address

JENNIFER 31. Date filed (Month, Day,

Year)

SEP 1

OBLES

HOPKINS

BAYVIEW CIRCLE BALTIMORE MD 24224

of person who completed cause of death (Item 23a) (Type, Print)

5505

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of or

| | | For State Registrar | | arytaric | | tificate o | f Death | | Reg. No. | US | 28940 |
|--|-----------------------------|---|--|------------------------------|--|---|--|--|---------------------------------|-------------------------------------|--|
| Physicia | | 1. Decedent's Name (First, Middle, Las Edward R. Dani | | | | | | 2. Date of Do | Day | Year 7008 | 3. Time of Death |
| /Medic Examin | | 4a. Facility Neme (If not institution, give Summ1t Park House | | Ctr | | 4b. City, Town | or Location of Dea | th | 4c. Count | y of Death | 7 |
| Funeral Director | | 215 10 7722 | ox 7. Ag | | ast birthday) 37 Yrs. | If Under 1 Year Months Day | | 8. Date of Bi (Month, D Nov 13 | rth ay, Year) , 1920 | 9. Birthp Coun Mary | lace (State or Foreign try) yland |
| /land | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | 11 | 0d. Inside City Limits |
| e Mary a-f eh | ctor | MD Baltimo | ore | | Catons | ville | | | | | 1 ☐ Yes 2 ☐ No |
| death with the Maryland me 23e or 28e-f ehow fraust be notified at | al Dire | 10e. Street and Number 1502 Frederick A | Avenue | | | 10f. Zip Code | 21228 | | 10g. Citizen of | What Coun | itry? |
| ъ <u>2</u> € | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forces? 1XYes 2 1 If Yes, Give Year or Dates: | Ever in U.S | | Vas Decedent of Yes, specify C | f Hispanic Origin? (Suban, Mexican, Puer lo <i>Specify:</i> | Specify Yes or Norto Rican, etc.) | Bla | ce - Americack, White, of the black | etc. |
| 215-0 thin 72 ho an *natur Medical | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | ucation de <i>completed)</i> College (1-4or 5 | i+) | (Give | lent's Usual Occ kind of work dor OO NOT use reti | ne during most of wo | orking unk | 16b. Kind of E | Business/Inc | dustry |
| d 21% | Соп | | nk | | | unk | 18 Mother's Na | me (First, Middle | 1 | | vernment unk |
| rianc | To Be | Tr. Tallist S. Valle (F. Hall, Milado, Eddi) | | | | ank | To. Motings 3 Na | and it has, who are | s, maioen ouman | | dik |
| Mary and 2 shou elith and h 27 is man or troums | | 19a. Informant's Name/Relationship (7 Summit Park Hous | | Ctr | | | et and Number or R | | | | |
| imore, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours alt ment of Heelth and Mental Hygiene. ant: It fem 27 is marked other than "natural", or ury or other treumatic event, the Medical Exert | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Removal from State) in State | ce | ace of Dispos metery, crem | sition (Name of natory or other p | place) | Date | 20c. Location | - City or To | wn, State |
| permit. Department imports ony inju | | 21. Signature of Euneral Service Licen | Wade Dir | ector | | | tomy Boar | | . Baltim | ore S | treet |
| Physician | | a. Part Enter the disc s- or comp shock or heart fail re. List only of Immediate use (Final disease or condition resulting in death) | olications that caused one cause greach line a. | ne. | . Do not ente | er the mode of d | Description of the Control of the Co | c or respiratory | arrest, | | Approximate Interval Between Onset and Death |
| /Medical Examiner | | | bue to (or as | a consequ | ence of): | | | | | | |
| uted d ansit | Examiner | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events | Due to lor as | a consulu | ence of | | | | | | |
| 68760, ifficate be execut g physicien and as the burial-tran | edicai Exa | resulting in death) Last | Due to (or as | a consequ | ence of): | | | | | | |
| | Completed by Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal | death 3 | Ectopic pregnal Other (specify) | | | | ate of delive | ory Day Year |
| cords, P. cords, P. tree thet the tree should be detailed by should be detailed. | d by Ph | Part II. Other significant conditions of | ontributing to death b | | lting in the un | derlying cause | given in Part I. | | tobacco use con | tribute to th | ne cause of death? |
| Division of Vital Records, to attending Physicien: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be contacted. | Complete | | | | | | | 24a. Was auto peri 1 Yes | opsy ormed? | prior to cor death? | psy findings available inpletion of cause of |
| f Vital Re system: The is certificate he director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | | 1,0 | No. 8 | ath (Check only | | | (|
| ion of Vita nding Physicien ah. r. Atler this certifi e funeral director | lon: To | 27. Manner of Death 1 ADatural 5 Pending | 28a. Date of Inju- (Month, Day | | PVOutpatient 28b. Time of Injury | 28c. In | ury at vork? | Home 5 Res 28d. Describe | how injury occu | | y) |
| Division of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral parts. | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | | ury - At hor c. (Specify) | me, farm, stre | | □Yes 2□No æ | | (Street and Num. own, State) | ber or Rura | l Route Number, |
| Hoepital or 24 hours afte Funeral Direction of the selection edicai C | 29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Examone) | /sician: To the best iner: On the basis of and manner sta | i examinati | vledge, death ion and/or inv | occurred at the estigation, in m | time, date and plac y opinion, death occ | e, and due to the urred at the time | cause(s) and m | anner as st | lated. the cause(s) |
| To the within 2 To the comple | Me | 29b. Signature and title of centrice | // | | | | nse number | , | 29d. Date signe | | |
| | | 30 Name and address of | Ser ampleted | DOUB /II | 230) | 00 | 006176 | 5 | 08- | 30 | -2005 |
| | | 30. Name and address of person who come the second | GOUNAUS | eath (Item | 375 | 5 WIL | KENS A | F#30 | OT BAL | T. My | 021225 |
| Stat Registra | | 31. Date filed (Month, Day, Year) SEP 1 0 2008 | 32, Registra | ar's Signati | ure f | | | | | | |

| | | | For State | State of Marylan | _ | rtment of F | | | giene Reg. No. 2 | 008 | 2894 |
|---------------------|--|----------------|--|---|----------------------------------|---|---------------------------------------|--|------------------------------------|--|---|
| r | | | Registrar 1. Decedent's Name (First, Middle, Las | it) | | imouto or | | 2. Date of De | ath | | 3. Time of Death |
| | Physicia | | Messa D. | RECMILLER | | | | SEPTEM | Day | Year | 454 |
| Q. | /Medic Examin | | 4a. Facility Name (If not institution, give | | 0 | 4b. City, Town, o | r Location of Dea | | | y of Death | ton |
| | | | NONTHINEST | HESpiTAL | Cente | 2 KAN | | OWN | | Timo | |
| а | Funeral | | 5. Social Security Number 16. So | ex 7. Age (In yrs. | last birthday) | If Under 1 Year Months Days | If Under 24 Hr Hours Mir | n (Manth. Da | ı <i>y, Year)</i> | Countr | ice <i>(St</i> ate or Foreign y) erland |
| | Director | | Usual Residence of Decedent | |) | | | 9/3/8 | 7/3 | SWILE | errand |
| | yland now at | | 10a. State 10b. County | 10c. Cit | y, Town or Lo | cation | | | | 100 | d. Inside City Limits |
| | a-f st | ctor | MD Baltin | nore | Reis | terstown | | | | | 1 ☐ Yes 2√ No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | What Countr | y? |
| | s 23a | | 111 W. Cherry Hi | | 0 140.1 | 2113 | | (On-sife V-s s) No | 14 Pa | USA ce - America | |
| | item item iner | Funeral | 11. Marital Status 1 ☐ Never Married 2☐ Married | 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [X] No | .5. | f Yes, specify Cub | an, Mexican, Pu | (Specify Yes or No erto Rican, etc.) | Bla | ick, White, et | |
| 936 | urs af | by | 3 XWidowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1□Yes 2XINo | Specify: | | Specit | y: Wh: | ite |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland that Hyglene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed | 15. Decedent's Ed (Specify only highest gra | | 16a. Deced | lent's Usual Occup | pation during most of w | vorkina | 16b. Kind of E | Business/Indu | ıstry |
| 21 | ithin "ne. | nple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. L | OO NOT use retire | d) | g | _ | | |
| 2 | filed w Hygier Ither th | Co | 12 17. Father's Name (<i>First, Middle, Last</i>) | | | Home | emaker | ame (First, Middle | | n Home | |
| and | d d d d | Be C | | | | | TO. WOULD STE | Mina Ho | | ine) | |
| 2 | d 2 should be fill th and Mental H 7 is marked oth traumatic even | ٦ | Caspar Gertsch 19a. Informant's Name/Relationship (7 | | 19b. Mailir | g Address (Street | and Number or i | Rural Route Numb | | , State, Zip (| Code) |
| Š | 1 and 2: Health a cem 27 is | | Michael J. Dreim: | iller Son | 111 | W. Cherr | cy Hill, | Reister | stown, l | MD 21 | 136 |
| altimore, | ges 1 and 2 should it of Heatth and Men If item 27 is marke or other traumatic | | 20a. Method of Disposition | / | Place of Dispo | sition (Name of natory or other pla | ce) | Date | 20c. Location | - City or Tow | n, State |
| Ĕ | Pages ment of ant: If its ury or o | | 1 X Bunal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specif</i> y | | nderhoo | k Cemete | ry 9/1 | 10/08 | Kinde | rhook, | , NY |
| Balt | permit. Pag Department Important: I any Injury o once. | | 21. Signature of Funeral Service Licen | see | | 2. Name and Addre | | | 4 Reist | | |
| - | ₫ O 등 @ O | | septe | m jeuge | | line Fune | | | terstown | | 21136 Approximate |
| Г | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final | one cause on each line. | | | | ac or respiratory a | irrest, | | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. Due to (or as a conseq | MAD (C) | my of | toty | | | | |
| | Examiner | | | (, | quenos on. | , , | | | | | |
| W | = 1 / = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a conseq | quence of): | | | | | | |
| | and I-transi | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | |
| 60, | ate be executed nysician and he burial-transi | E E | resulting in death, East | Due to (or as a conseq | juence of): | | | | | | |
| 68760 | 75 | dical | | d | | | | | | | |
| Box | w requires that the death certific been signed by the attending p should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome pf pregna | | | | | 23d. D | ate of deliver | v |
| | death | iciai | in the past 12 months? | 1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c | |]Ectopic pregnanc]Other (specify) _ | :y | | | | Day Year |
| о. О | at the by the tache | hys | 9 ☐ Unknown | 9□ Unknown | | | | | | | |
| | es tha | ру Р | Part II. Other significant conditions of | // | _ | - 0 | | | _ | | e cause of death? |
| ord | requir een s | ted | SEVENE BUILDE | skry HypEnt | ENSID | S Conc. | CETIVE | - 1 | Yes 2 No | 3 ☐ Proba | ibly 4 Illinknown |
| Vital Records, | has b | Completed | HAAT Tables | = Serzun | E Di | CORDER | | 24a. Was | psy | . Were autop prior to com death? | sy findings available pletion of cause of |
| <u></u> | | | | , | | | | 1□ Yes | ormed? 2 No | 1 Yes 2 | 2 NO |
| | Physician: The la rthis certificate has ral director, page 2 | Be o | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: |] ER/Outpatier | t all pos Ott | nor. | eath (Check only | | | |
| ō | y Phy er this eral di | : To | 27. Manner of Death | 28a. Date of Injury | 28b. Time o | IL 3 DOA | 4 Li Nursing | Home 5 ☐ Res 28d. Describe | how injury occu | |) |
| <u>o</u> | Attending Ph or death. rector: After th by the funeral | atior | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | | rk?]Yes 2 ☐ No | | | | |
| Division or | Attender death | tifica | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of injury - At h building, etc. (Specia | | eet, factory, office | | | (Street and Num | ber or Rural | Route Number, |
| | ital or irs aft ral Di | Certification: | | | | | | | | | |
| | Hosp 4 hou Fune tely fil | ical | (Check only 2 Medical Exam | nysician: To the best of my kno niner: On the basis of examina | owledge, deat ation and/or in | h occurred at the t vestigation, in my | ime, date and pla opinion, death o | ace, and due to the ccurred at the time | cause(s) and n , date and place | nanner as sta e, and due to | ated. the cause(s) |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, | Medical | one) 29b. Signature and title of certifier | and manner stated. | | 29c. Licens | se number | | 29d. Date sign | ed (Month. F | Day, Year) |
| | F ≥ F 8 | -ir |) (d) | 1 BM | D | D | 19502 | | SENTER | Die | & sand |
| , | 1 | | 30. Name and address of person who | completed cause of death (Iter | m 23a) (Type. | Print) | No | 774.) | HAND | The | Pulm |
| | 5 | | ORLANDO B. | CONGUEN 1 | ne) | · | BANDO | 174627 |) het | 1. 2 | (33) |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 32 Registrar's Signa | ature | -02 | | | | | |

28942 State of Maryland / Department of Health and Mental Hygiere 00 Certificate of Death

Physicia /Medica Examine

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Importent: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Wedical Examinational Perportities at once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| | 1. Decedent's Name | e (First, Middle, | Last) | | | | | | | 2. Date of De | ath | | | 3. Time of | Death |
|------------------|--|--|--|---|-----------------------------|----------------------------------|-----------------------|---------------------------|-------------------------|---|----------------------|----------------------|--------------------------|---------------------------|--------------|
| 1 | 1 | | = | | | | | | | Month | O/ | | Year | 1150 | |
| 1 | 4a Facility Name (I | f not institution | give street and number | -) | | 4h City | Town or | Location | of Death | 0-1 | | . County | | IIA | <u> </u> |
| | | | | | D | 1 | | | _ | - | | | | | _ |
| | 5. Social Security N | | | ge (In yrs. las | KEH. | If Under | 1 Year | If Under | 24 Hrs. | 8. Date of Bi | | JAL | | HOP | |
| ĺ | · | | 1 ☐ M 2 tot F | 99 | Yrs. | Months | | Hours | Min. | (Month, D | ay, Year) | | Coun | try) | il i oreigii |
| - | 218-26- Usual Residence of | | 11 | | | | | | | <u>5–28-</u> | -1909 | 9 | VIRG | INIA | |
| 1 | 10a. State | 10b. County | | 10c. City, | Town or Lo | cation | | | | | | | 10 | 0d. Inside C | ity Limits |
| 5 | MD | NT / | A | | ALTIM | | | | | | | | | | 2 🗆 No |
| 2 | MD. | N/A | A | D | ALLIN | | | | | | | | | 21 | |
| 5 | 10e. Street and Nur | mber | | | | 10f. Zip | Code | | | | 10g. Ci | tizen of V | Vhat Coun | try? | |
| 2 | 906 N. | WARWIC | K AVE. | | | 2 | 1216 | | | | | USA | A | | |
| ruileiai Dilecio | 11. Marital Status | | 12. Was Deceder Armed Forces | t Ever in U.S. | 13. \ | Was Dece | dent of Hi | spanic Ori | igin? (Spi | ecify Yes or N Rican, etc.) | 0- | | e - Americ k, White, | | |
| 2 | 1 Never Marri | ied 2□ Marnie | | | | 1 🗆 Yes | • | Specify: | | , | | | | | |
| 2 | 3X Widowed | 4 Divorced | Year or Dates | : | | 1 🗀 1 63 | ZUXVO | Specify. | | | | Specify | . BF | ACK | |
| completed by | (Case | 15. Decedent's | s Education grade completed) | | 16a. Deced | dent's Usu kind of wo | al Occupa | tion | t of work | ina | 16b. K | (ind of Bu | siness/Inc | lustry | |
| ᇍ | | | College (1-4o | 5+1 | life. l | DO NOT U | se retired, | uring mos | St Of WORK | irig | | | | | |
| 5 | Elementary/Seco | - | -0-1 | 31, | HOU | SEKEI | EPING | ; | | | I | DOMES | STIC | | |
| וט | 17. Father's Name | (First, Middle, L | ast) | | | | | 18. Moth | er's Name | e (First, Middle | , Maider | Sumam | re) | | |
| 3 | JOHN K | ING | | | | | | SU | SIE . | JACKSON | 1 | | | | |
| - | 19a. Informant's Na | ame/Pelationsh | in (Type Print) | | 19h Mailin | a Address | (Street a | nd Numb | er or Run | al Route Numb | or City | or Town | State 7in | Code | |
| | | | | | | | | | | BALTIN | , | | · | | 15 |
| - | | -// | NCE(NIECE) | 20h Blo | ce of Dispo | | | 11151 | | DALLIF | | | City or To | | |
| | 20a. Method of Disp | | 3 □Removal from Stat | | netery, cren | natory or | other place | 9) | | Jaio | 200. L | ocation - | City of 10 | wn, State | |
| | ^¹ 4 □ Donation | | | ARBU | TUS M | EMOR: | IAL P | ARK | 9-10- | -2008 | BALT | FIMOF | RE, M | ARYLA | ND. |
| | 21. Signature of Fo | meral Service | cense JONATAIA | N D. H | IBNER | . Name ar | nd Addres | s of Facili | yPHI: | LLIPS E | UNE | RAL F | IOME. | P.A. | |
| | | nath | L'illK | Ball | | | | | | ST. BAI | | | THE RESERVE | | 21217 |
| | 23a. Part1. En er ti | he disease, or d | complications that cause | ed the death. | | | | | | | | - 22 | - 1 | Approximat | te |
| | shooy, of hea Immediate Quuse | | nly one cause on each | line. | | | | | | | | | | Onset and | |
| | disease of distriction resulting death) | (Filla) | a | Inan | itim | | | | | | | | - 1 | ew u | ileks |
| | resulting - dealth) | | Due to (or a | s a conseque | | | | | | ür. | | | | l: | , |
| | Sequentially list co | nditions | b | Senil | e i | Dem | entre | 2 01 | 14/1 | beine | 4/ | 4.00 | 5 | Rula | 14861 |
| 2 | If any, leading to in | imediale | Dus to (or a | s a conseque | noe orj. | | | 1 | U | | (| 11 | | | *10 |
| LVall | cause. Enter Unde Cause (Disease or that initiated events | \$ | с. | | | | | | | | | | | | |
| | resulting in death) I | Last | Due to (or a | s a conseque | nce of): | | | | | | | | | | |
| 5 | | 1 | d. | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| //wedled | IF FEMALE: 23b. Was deceden | t oregnant | 23c. If yes, outcom | | | | | | | | | 23d. Dat | e of delive | rv | |
| 3 | in the past 12 | months? | 1 ☐ Live birth 4 ☐ Pregnant | | |]Ectopic p] Other <i>(st</i> | | | | | | Moi | | - | Year |
| 2 | 1 Yes 2 Dunknown | | 9□ Unknown | | | 3 011101 (0) | | | | | | | | | |
| | | | s contributing to death | but not result | ing in the | nderlying r | cause muc | n in Part I | | 23e Did | tobacco | use conti | ribute to th | e cause of o | death? |
| 2 | Bito | 2)00 h . 1 | Hi nit | n n | garuio di | | Ĭ | | | - 10 | | _ 4 | 3 Prob | | Unknown |
| Bosold | USIE | 09(3(1)31 | 112 (1514 | <u> </u> | 115)(| cruj. | estru | <u> </u> | | '' | Yes 2 | Z/No | 3 🗀 🗀 | ably 4 🔠 | JIIKIIOWII |
| 2 | hoon | t Fee | iluré | , | | V | | | | 24a. Was | an | 24b. V | Vere autor | osy findings | available |
| 5 | | | | | • | | | | | _ perf | ormed? | | leath? | 2□ No | ause of |
|) | 25. Was case refer | red to medical | | | | | | OF Place | o of Dogst | 1 ☐ Yes | 2 N | | 162 | 2 140 | |
| | examiner? | | Hospital: | | 2/0: | | Othe | ar . | | | | | | | |
| 1 | 1 ☐ Yes 2 🙀 27. Manner of Deat | | 28a. Date of In | | R/Outpatien 8b. Time of | | JA | 4 A NI | | me 5 Res 28d. Describe | | | | ′) | |
| | 1 Natural | 5 Pending | (Month, E | ay Year) | Injury | | 28c. Injury Work | | | ZOU. Describe | now inju | ny occum | θú | | |
| 5 | 2 Accident | investiga 6 Could no | ot be | | | М | | /es 2□ | | | | | | | |
| | 3 ☐ Suicide 4 ☐ Homicide | determin | ned 286. Place of I | njury - At hom etc. <i>(Specify)</i> | e, farm, str | eet, factor | y, office | | | 28f. Location City or To | | | er or Rura | Route Num | ıber, |
| 3 | | | | | | | | | | | | | | | |
| _ [| | | | | | | | | | | | | | | |
| 3 | 29a. Certifier | 1 Certifying | Physician: To the bes | t of my knowl | edge, death | occurred | at the tim | e, date ar | nd place. | and due to the | cause(s | and ma | nner as st | ated. | |
| 2 | 29a. Certifier (Check only one) | 1 Certifying 2 Medical E | Physician: To the bes xaminer: On the basis and manner | of examinatio | edge, death n and/or inv | occurred vestigation | at the tim | e, date ar pinion, dea | nd place, ath occurr | and due to the red at the time | cause(s , date an | and ma d place, a | nner as st and due to | ated. the cause(s | ş) |
| 200 | (Check only | 2 Medical E | xaminer: On the basis | of examinatio | edge, death n and/or inv | vestigation | at the time, in my op | oinion, dea | nd place, ath occurr | and due to the red at the time | , date an 29d. Da | d place, a | and due to | the cause(s | |
| 5 | (Check only one) 29b. Signature and | title of certifier | xaminer: On the basis and manner | of examinatio | edge, death n and/or inv | vestigation 29 | c. License | number | ath occurr | and due to the red at the time | , date an 29d. Da | d place, a | and due to | the cause(s | |
| 5000 | (Check only one) 29b. Signature and | 2 Medical E title of certifier Nor Ca | xaminer: On the basis and manner: | of examinatio | n and/or inv | vestigation | c. License | number | ath occurr | red at the time | 29d. Da | d place, a | Month, | the cause(s Day, Year) | |
| 5000 | (Check only one) 29b. Signature and ACC C. C. 30. Name and addr | title of certifier Mon Corresponding to the control of the certifier of t | xaminer: On the basis and manner: | of examinatio | n and/or inv | vestigation | c. License | number | ath occurr | red at the time | 29d. Da | d place, a | Month, | the cause(s Day, Year) | |
| | 29b. Signature and Lace C. 30. Name and addr | 2 Medical E title of certifier Nor Day ress of person w | xaminer: On the basis and manner: | of examinatio | n and/or inv | vestigation | c. License | number | ath occurr | red at the time | 29d. Da | d place, a | Month, | the cause(s Day, Year) | |
| | (Check only one) 29b. Signature and ACC C. C. 30. Name and addr | 2 Medical E title of certifier Nor Day ress of person w | xaminer: On the basis and manner: | of examinatio | n and/or inv | vestigation | c. License | number | ath occurr | and due to the red at the time | 29d. Da | d place, a | Month, | the cause(s Day, Year) | |

10

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 28943

| | | | 1 - State of Maryland / Department of Maryland / Department of Maryland / Depart | tificate of Death | | g. No. | 28943 |
|------------|--|----------------|--|---|--|---|--|
| П | Physici | ian | 1. Decedent's Name (First, Middle, Last) | | Date of Death Month | Day Year | 3. Time of Death |
| and. | /Medi | cal | SANDRA MELISSA ECTOR 4a. Facility Name (If not institution, give street and number) | Al. Oit. Town or Leasting of Dooth | AUGUST | 28, 2008 | 1910 M |
| | Examir | ner | SOUTHERN MARYLAND HOSPITAL | 4b. City, Town, or Location of Death CLINTON | | 4c. County of Deat | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, | 9 Birt | hplace (State or Foreign |
| | Director | | 219-06-5635 1□ M 2☒ F 39 Yrs. | Months Days Hours Min. | SEP 12, | | uintry) |
| | and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc | ation | | | 10d. Inside City Limits |
| | Maryl Fred | to | MD PRINCE GEORGE'S TEMPLE HI | LLS | | | 1 X IYes 2□No |
| | or 28a | Director | 10e. Street and Number | 10f. Zip Code | 10 | g. Citizen of What Co | untry? |
| | th wit | | 3081 BRINKLEY ROAD #102 | 20748 | | USA | |
| | tems | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. V Armed Forces? | las Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Ame Black, White | |
| 36 | rs afte | by F | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 | ☐Yes 2X No Specify: | | Specific. | BLACK |
| 21215-0036 | be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, its Madical Evaniner must be notified at | ted | 15. Decedent's Education 16a. Deced | ent's Usual Occupation | | 6b. Kind of Business/ | |
| 21,5 | thin 7 ne. ian "n | Completed | (Specify only highest grade completed) (Give life. Lif | kind of work done during most of work O NOT use retired) | ing | | |
| | led wi lygier her th | | | TS PAYABLE CLERK | | PBS | |
| anc | be de de | Be | 17. Father's Name (First, Middle, Last) CHARLES R. ECTOR. SR | | e <i>(First, Middle, M</i> EE G。 STE | • | |
| Maryland | ina Pictor | ျ | | Address (Street and Number or Rui | | | Zin Code) |
| | ra is | | | OLD SILVER HILL R | | TLAND, MD | 20746 |
| Š. | of Fe T | - | 20a. Method of Disposition 20b. Place of Dispos | | | Oc. Location - City or | |
| Ĕ | Pages ment of ant: If Its ury or o | | 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND | : | -2008 | LAUREL, MD |) |
| Baltimore, | permit. Page Department of Important: If any injury or once. | | | Name and Address of Facility MAR | | | |
| | EU = 80 | | A Dominio in Oldin | 308 SUITLAND ROAD | | TLAND, MD | 20746 |
| | | | 23a. Par 1. Inter the disease, or o mplications that caused the death. Do not ente ships, or heart failure. List only one cause on each line. | | or respiratory arre | st, | Approximate Interval Between Onset and Death |
| ** | Physician /Medical | | disease or condition resulting in death) a. b: lateral priving | noneg | | | unknown |
| | Examiner | | Immediate Cause (Final disease or condition resulting in death) a. b. (a teral) nound Due to (or as a consequence of): Sequentially list conditions b. Mctastatic brea | et Canin | | | lisknown |
| | P. /# | ner | Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | Carros D | | | |
| | executed n and al-transit | Examiner | Cause (Disease or injury that initiated events c. | | | | |
| Ď, | | | Due to (or as a consequence of): | | | | |
| 09/89 | certificate be Iding physicia se as the bur | Medical | d | | | | |
| XON | n certi ending use a | n/M | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | 23d. Date of del | iverv |
| ň | death | sicia | in the past 12 months? 1 Live birth 2 Fetal death 3 Live birth 2 Fetal death 3 Live birth 2 Fetal death 5 Live birth 2 Fetal death 3 Live birth 2 Fetal dea | Ectopic pregnancy Other (specify) | | Month | Day Year |
| 7. O | at the | Physician// | 9 ☑ Unknown | | | | |
| Š | res th signed be de | ρ | Part II. Other significant conditions contributing to death but not resulting in the unc | derlying cause given in Part I. | .11 | acco use contribute to | |
| ecords, | been | Completed | | | 1 Yes | 2 No 3 Pr | obably 4/X Unknown |
| ě | ne law has l ge 2 s | фш | | | 24a. Was an autopsy perform | prior to o | topsy findings available completion of cause of |
| N I | in: Th | ပိ | 25. Was case referred to medical | | 1 ☐ Yes 2 | XNo 1 ☐ Yes | 2 X No |
| 5 | ysicia s cert direct | o B | examiner? 1 □ Yes 2 ☒No Hospital: 1 ☒ Inpatient 2 □ ER/Outpatient | 26. Place of Death | | ce 6 ∐Other <i>(Spec</i> | -76.4 |
| 5 | g Phy ter thi neral o | \vdash | 27. Manner of Death 28a. Date of Injury 28b. Time of | | 28d. Describe how | | сту) |
| VISION | endin sath. or: Af he fur | atio | 2 Accident investigation | M 1 ☐Yes 2 ☐ No | | | |
| <u>"</u> | or Atter de irecton by t | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify) | et, factory, office | 28f. Location (Stre | eet and Number or Ru State) | ral Route Number, |
| ָׁב | pital c | | 200 Cortifica | | | | |
| : | To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use | Medical | 29a. Certifier (Check only one) 2D Medical Examiner: On the basis of examination and/or invance on the basis of examination and the basis of examination an | occurred at the time, date and place, estigation, in my opinion, death occur | and due to the car red at the time, dat | use(s) and manner as te and place, and due | stated. to the cause(s) |
| | To the within To the sompl | Me | 29b. Signature and title of certifier | 29c. License number | 296 | d. Date signed (Month | ı, Day, Year) |
| | | | Point Fact M.D | Da3456 | | 8.29.0 | |
| | 10 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, P | rint) | - 0 | | |
| | l | | ROINTAN FARAHIFAR M.D. 9801 | Georges Ave suit | J-32 Sik | rulfring | MD 20902 |
| | Stat Registra | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | 49 | | 9 | |
| DHM | 1H 17 Rev 1/20 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, PROINTAN FARAHITAR M.D. 9801 31. Date filed (Month, Day, Year) SEP 1 0 2008 | <u> </u> | | | |

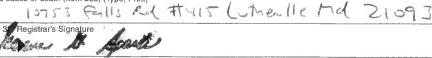
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** Month Keainald VERETT 5:50 PM September 2008 /Medical 02 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Baltimore Bon Secours Hospital Date of Birth (Month, Day, Year) Jan 14, 1947 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Months Hours Min. 1 ★M 2 ☐ F Maryland Director 61 218-44-8265 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Baltimore Director n/a Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 U.S.A. 21217 1200 North Woodyear Street filed within 72 hours after death v Hygiene. Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐**X**No Black Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Up-To-Date Laundry Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mazie Boone Thurman Everett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Woodyear Street' Baltimore, Maryland 21217 Marjorie Moore Everett Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/10/08 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signatur Funeral Service Licenses 22. Name and Address of Facility any in Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Men 23a. Part 1. Enfer the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ericardial SION /Medical Due to (or as a consequence of): Examiner Exquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical as attending IF FEMALE: for use yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐ Yes 2 🗷 No 1 🗆 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 Inpatient 2 RER/Outpatient 3 □ DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) Can D. D. D41734 5 eptember 03, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W. Baltimore St. Baltimore, MD M. ChRISTINE JACKSON M.D 31. Date filed (Month, Day, Year) 32_™Registrar's Signature State Registrar

| 3 | | | _ State | te of Maryland / [| Department of Health and Certificate of Death | | 2000 | 28945 |
|----------------------------|---|------------------|---|--|---|---|---|--|
| | | | 1. Decedent's Name (First, Middle, Last) | | Cerificate of Death | 2. Date of Dea | Reg. No. | 3. Time of Death |
| | Physici | | Arethea | Evans | | Month | May y day | 2 |
| | /Medic Examir | | 4a. Facility Name (If not institution, give street a | | 4b. City, Town, or Location of Dea | | 4c. County of Deat | |
| 300 | | | Moryland Genera | 1 Hospita | 1 Saltinic | City | ^ | 1/1 |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 | 7. Age (In yrs. last bit | rthday) If Under Year If Under 24 Hrs Months Days Hours Min | | 9. Birth | nplace (State or Foreign untry) |
| | | | Usual Residence of Decedent | | | J F GD, 1 | 1,10011111 | |
| | anylar ehow | 2 | 10a. State 10b. County | 10c. City, Tow | Baltimore | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | the N | recto | 10e. Street and Number | | 10f. Zip Code | | 10g. Citizen of What Co | |
| | within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-1 show to Modical Esantiner must be notified at | Funeral Director | 420 Orchard St. | | 21201 | | ust | |
| 5 | lteme | Iner | Arr | is Decedent Ever in U.S. ned Forces? | 13. Was Decedent of Hispanic Origin? (| Specify Yes or No- rto Rican, etc.) | 14. Race - Ame Black, White | |
|) 36 | rs afte | by Fi | If Y | Yes 2 TM6 es, Give ar or Dates: | 1 ☐ Yes 2 ☑ No Specify: | | Specify: Bla | ck |
| 5-0036 | 2 hou atura | ted | 15. Decedent's Education | 16a | . Decedent's Usual Occupation | dela a | 16b. Kind of Business/ | Industry |
| 77 2 | fithin 7 | Completed | (Specify only highest grade comp | llege (1-4or 5+) | (Give kind of work done during most of wo life. DO NOT use retired) | orking | Privat | P) |
| d 21 | 77 75 1 | Co | 17. Father's Name (First, Middle, Last) | | Catever 18 Mother's Na | me (First, Middle, | Maiden Sumame) | |
| ⊴ <u>a</u> | lid be fental rked o | To Be | George Evans | | | e Towso | | |
| ary | s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event, | - | 19a. Informant's Name/Relationship (Type, Pri | nt) 19b | o. Mailing Address (Street and Number or F | | | (ip Code) 21202 |
| J. S | and 2 ealth m 27 i | | Arita Beasley -da | the state of the s | 40 McAleer Gt | - Balti | more Mar | yland |
| Jore | 8 = 5 | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remova | I from State | f Disposition (Name of ry, crematory or other place) | Lalas | 20c. Lo stion - City or | Town, State |
| Baltimor | | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funegal Service Licenses | King | Memorial Hork 9 22. Name and Address of Facility | 10/00 | Rar Auristo | or PA |
| G & | permit. Departm Importa eny inju | | · fevin fa | Ker | 3512 Frederick | Ave Ro | Hinare N | Janua 1229 |
| | | | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus | s that caused the death. Do | not enter the mode of dying, such as cardia | ic or respiratory ar | rest, | Approximate interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Intracar | tra Hemorat | lage | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequence | of): |) | | |
| | | er | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence | Cidney /) 15ea 5 a | <u>Z</u> | | |
| V | cuted | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | Valetes | Mellites | | | |
| ,09 | icate be executed physicien and s the burial-transit | EX | resulting in death) Last | Oue to (or as a consequence | of): | | | |
| 68760; | | edical | d | | | | | |
| Вох | eath certif attending for use a | n/Me | | es, outcome of pregnancy | a 🗆 = | | 23d. Date of del | ivery |
| B | death | Physician/M | in the past 12 months? |]Live birth 2 ∏Fetal death]Pregnant at time of death]Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | Month | Day Year |
| P.O. | hat the d by ti | Phy | 9 ☐ Unknown 9 ☐ Part II. Other significant conditions contribution | | n the undertains access awas in Red I | 220 Didto | bacco use contribute to | the gause of death? |
| Division of Vital Records, | Attanding Physician: The law requires that the death certificateh. r death. ector: After this certificate hes been signed by the attending by the funeral director, page 2 should be delached for use a | d by | atti. Still significant continues | ig to death but not resulting i | in the underlying cause given in Fart i. | | es 2 □ No 3 □ Pr | |
| Lo | s been s been shou | lete | , , , , | | | 24a. Was | an 24b. Were au | topsy findings available |
| Re | The lav | Completed | | | | autop perfor 1 ☐ Yes | sy prior to death? 2 No 1 ☐ Yes | completion of cause of |
| /ita | ysician: The is certificate he director, page | Bec | 25. Was case referred to medical examiner? | | 26. Place of De | ath (Check only or | | |
| -fo | Physi this c al dire | ပ္ | 1 Yes 2 No Hospita | 1 Sunpatient 2 EH/OL | | | dence 6 □Other (Spec | cify) |
| O | ding Phy th. After thi funeral | tlon | 1 Natural 5 Pending 2 Accident investigation | | Time of linjury at Work? M 1 ☐ Yes 2 ☐ No | 28a. Describe n | low injury occurred | |
| visi | Attendil er death. ector: A by the fu | Certification; | 2 ☐ Suicido 6 ☐ Could not be | Place of Injury - At home, fa building, etc. (Specify) | | 28f. Location (S City or Tow | Street and Number or Ru | iral Route Number, |
| Ö | ital or rs after rei Dir led in | Cert | | | | | | |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi | Medical | (Check only 2 Medical Examiner: Or | To the best of my knowledge the basis of examination and manner stated. | e, death occurred at the time, date and place d/or investigation, in my opinion, death occ | e, and due to the curred at the time, o | cause(s) and manner as date and place, and due | stated. to the cause(s) |
| | ro the vithin 2 or the comple | Med | 29b. Signature and title of certifier | d marmer stated. | 29c. License number | | 29d. Date signed (Monti | h, Dey, Year) |
| | > 0 | | > Snother Kan | ltgejner | 89579 | | 9-4-05 | 2 |
| - | 7 | | 30. Name and address of person who complete | d cau e f death (Item 23a) | (Type, Print) | > \ C | - 11 | |
| 725- | | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | . / | yland G | (Survey | 0521tal |
| | Sta Registr | | SEP 1 0 2008 | 13 /6 | and I | | | |

10

State 31. Date filed (Month, Day, Year)
Registrar SEP 1 0 2008



| | | For State Registrar | | Maryland / i | - | | | ealth a Death | and M | F | Reğ. No. | 8 289 | 47 |
|--|----------------|--|---|---|--------------------|---------------------------|--------------------------|----------------------------|------------------------|---|---------------------------------------|---|--------------------|
| Physicia /Medica | | 1. Decedent's Name (First, Mide Olease | • | eegal | | | | | | 2. Date of Dea Month | 2 Pay | 3. Time of 2008 | Death M |
| Examine | | 4a. Facility Name (If not instituti | on, give street and numb | oer) | | 4b. City, | Town, or | Location o | of Death | | 4c. County of | of Death | |
| | | BALTIMERS DI | JEHRNGTON | Memcal | 15 | TIFR | G | IBN | Bu | RNIE | ANHE | 1 APUNI | 1FI |
| Funeral | | 5. Social Security Number | | Age (In yrs. last bit | rthday) | If Under Months | 1 Year Days | If Under : | 24 Hrs. Min. | 8. Date of Birth (Month, Day july 0 | Year | Birthplace (State of Country) | r Foreign |
| Director | | 220-16-7420 | 1□M 2및F | 83 | Yrs. | MONUS | Days | Hours | IVIII I. | july 0 | 2 1925 | MD | |
| D > | - | Usual Residence of Decedent 10a. State 10b. Count | N. | 10c. City, Tow | m or l o | | | | | | | 101 1-11-01 | |
| aryla shov | _ | | • | roc. City, row | n or Lo | cation | | | | | | 10d. Inside Cit | - |
| r 28a-f show | Director | | e Arundel | | | 1 | | Gler | n Bu | | | | |
| 불 으셨 | ב | 10e. Street and Number 7466 Furnace | Branch Doad | | | 10f. Zip | Code | 2100 | -0 | | 10g. Citizen of W | | |
| death w | Funeral | | | | 10.14 | Van Dess | 14 -4 1 E | 2106 | | | 14 Peac | USA | |
| ter di | Š. | Marital Status Never Married 2 Ma | 12. Was Decedor | es? | IS. V | Yes, spec | offy Cuba | n, Mexican | , Puerto | ecify Yes or No- Rican, etc.) | Black | - American Indian, k, White, etc. | |
| | 2 | 3 ₩ Widowed 4 Divorce | If Yes Give | | 1 | ☐ Yes | 2 🙀 No | Specify: | | | Specify: | White | |
| P of sum | ed | 15. Decede | ent's Education | | . Deced | lent's Usua | I Occupa | ition | | | 16b. Kind of Bus | siness/Industry | |
| within 72 see. | Completed | (Specify only high Elementary/Secondary (0-12) | est grade completed) College (1-4 | or 5 + \ | (Give I life. [| kind of wor DO NOT us | rk done d se retired, | luring most) | of work | ing | | , | |
| Hiled with Hygiene with the the | E | 12 | College (1-4 | 01 5+) | | НС | mema | ker | | | Но | usehold | |
| □ = ± 5 5 | Bec | 17. Father's Name (First, Middle | e, Last) | | | | | 18. Mothe | r's Name | (First, Middle, | Maiden Sumame | 9) | |
| 수 무취 본 의 | 0 | Grover | Toft | | | | | Jes | sam: | ine E. | Her | ndon | |
| Maryla d 2 should Ith and Men 7 is marke traumatic | | 19a. Informant's Name/Relation | nship (Type, Print) | 196 | . Mailin | g Address | (Street a | nd Numbe | r or Rura | al Route Numbe | r, City or Town, S | State, Zip Code) | |
| Te, N | | Jean Eckstorm | (daughte | r) 1 | .12 | Touhe | y Dr | ive, | Ste | vensvill | Le, MD 2 | 1666 | |
| Saltimore, Mary narmit. Pages 1 and 2 shou Department of Health and M mportant: if item 27 is ma iny injury or other trauman ince. | | 20a. Method of Disposition | . D | 20b. Place o cemete. | f Dispos | sition (Nan | ne of ther place | 9) | Sept | Date 11 | 20c. Location - 0 | City or Town, State | |
| Pages nent of l | 1 | 1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (| | Cedar | | - | | | | 200 | Baltimor | e, Marylar | ıd |
| Baltim parmit. Pag Department Important: I any injury o | - | 21. Signature of Funeral 5 vio | Lidy ree | | | | | s of Facility | у | | | al Home, F | |
| Dep para | | bul d. | Jan Gh | • | 4 | 3111 | Mou | ntain | | | dena, MD | | |
| | | 23a. Part1. Enter the disease, shock, or heart failure. Lis | or complications that cause on each | sed the death. Do | not ente | er the mod | e of dying | g, such as | cardiac c | or respiratory arr | rest, | Approximate Interval Betv | i Vaen |
| Physician | ļ | Immediate Cause (Final disease or condition | Mand | - Con Ats | 7 | 21, | | | | | | Oncot and D | |
| /Medical | | resulting in death) | a. Due to (or | as a consequence | of): | ecc | | , | 11.07 | 34. (-) | rseses | | |
| Examiner | | Sequentially list conditions | CHETZY | LIC OBG | TRO | CTIV! | EK | ulmo | MA | PM 2 | rseaso | 2 | |
| A D = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or | as a consequence | of): | | | | | | | | |
| 60, % be exacuted be exacuted burial-transi | Examiner | Cause (Disease or injury that initiated events | С | | | | | | | | | | |
| sa exgan a sian a urial- | T | resulting in death) Last | Due to (or | as a consequence | of): | | | | | | | | |
| 87 ate ate | dical | | d | | | _ | | | | | | | |
| 9 4 5 8 | a - | IF FEMALE: | | | | | | | | | | | |
| death cert e attendin | Pnysician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outco 1 ☐ Live birtl | me of pregnancy n 2 ☐ Fetal death | 3 🗆 | Ectopic pr | egnancy | | | | 23d. Date Mon | of delivery th Day Y | ear |
| O. E. the a the a hed for | 2 | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4□Pregnan 9□Unknow | it at time of death | 5 🗌 | Other (sp | ecify) | | | | WIGHT | ui Day i | od: |
| that the dead by the detached | Ę | 8 | | | | | | | | | | Contract Contract | |
| | 2 | Part II. Other significant condit | ions contributing to deat | n but not resulting ii | n the un | derlying ca | ause give | n in Part I. | | | | bute to the cause of de | |
| w raquir been si should I | led | | | | | | | | | 1 U Y | es 2 No | 3 Probably 4 | nknown |
| Vital Records, sician: The law requires the certificate has been signal rector, page 2 should be or the control of the control | Completed | | | | | | | | | 24a. Was a autops | an 24b. W | ere autopsy findings a for to completion of ca | vailable use of |
| The The page | 5 | | | | | | | | | perfor | med?/ de | eath? ☐ Yes 2 ☐ No | |
| Vital Fician: The ician: The certificate rector, pag | | 25. Was case referred to medic examiner? | | | | | | 26. Place | of Death | (Check only or | 7e) | | |
| # SE E | 2 | 1 ☐ Yes 2 ☑ No | Hospital: 1 Inp | | - | | | 4 🗆 1401 | rsing Ho | me 5 🗆 Reside | ence 6 Othe | r (Specify) | |
| Junera | 0 | Manner of Death Natural 5 ☐ Pend | mrg | njury 28b. 1 Day Year) I | Time of njury | | Bc. Injury Work | | | 28d. Describe h | ow injury occurre | d | |
| | Certification; | 2 Accident inves | tigation | | | М | | ′es 2□N | - | | | | |
| or At fler of pirect n by | | | mined 286. Place of | Injury - At home, fa , etc. <i>(Specify)</i> | ırm, stre | et, factory | , office | | | 28f. Location (Si City or Town | | r or Rural Route Numb | 101, |
| oital ours a srail D | 2 | | | | | | | | | | | | |
| Division To the Hospital or Attant within 24 hours after dealt To the Funeral Director: completely filled in by the | edical | 29a. Certifier 1 Certify. (Check only 2 Medica | ing Physician: To the be I Examiner: On the basi | s of examination an | death dor inv | occurred a estigation, | at the tim in my op | e, date and inion, deat | d place, a h occurr | and due to the c ed at the time, d | ause(s) and man late and place, ar | ner as stated. nd due to the cause(s) | |
| the I | | one | and manner | stated. | | | . License | | | | | | |
| To To Con | | 29b. Signature at title of certifi | 0 | Min | | 290 | 25 | T T | as | | 3d. Date signed | (Month, Day, Year) | James G |
| | | ~~~ | ug | ú | ر | 2 | 7 | 2, | 7 | 1 | repo en | rye/ 3 a | 000 |
| 4 | | 30 Jame and address of person | who completed cause | death (Item 23a) | (Type, F | Print) | 1 | NO | CI | 2 2 | 111/210 | Min an | 16-4 |
| Con | _ | 31. Date filed (Month) Day, (Yea | 32 890 | istrar's algnature | 210 | ريد د | u (| 46 | 70 | en is | mille | 1110 00 | 10, |
| State Registra | r | 31. Date filed (Month) Day (Y2) | TUB STEELE | 15 19 | STEL. | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Benedict Henry German Jr. <u>September 8</u> 2008 8:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10415 Cavey Lane Woodstock Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 218-12**-**8130 87 **Director** June 25 1921 Usual Residence of Decedent with the Maryland f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f shorthe Medical Exeminer is ust be notified at MD Howard Woodstock Director 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10415 Cavey Lane 21163 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 □Yes 21√2 No <u>გ</u> Specify: Specify: white 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction carpenter permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benedict Henry German Sr. Catherine Boone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William German (son) 1580 Deer Park Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 9-13-08 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home 🖁 Chapel Paigrapaight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VOA **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duc to (or as a consequence of): The law requires that the death certificate be executed burial-transit the attending physician and ned for use as the hirial-tran-Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 🗌 Yes 2K No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has t funeral director, page 2 s 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who complet BROWN LOAD ELKRIDGE MD 21075

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0

1 E.D

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** M GEE SEP 02 2008 10:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BRADFORD OAKS NURSING HOME PRINCE GEORGE'S CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min Director 101 APRIL 25, 1907 VA 578-20-4314 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Modical Examinar must be redified at Director 1 X Yes 2 No MD PRINCE GEORGE'S BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11401 CROSS ROAD TRAIL Funeral 20613 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ∑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 🖾 No Specify. þ 3 X Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3RD DOMESTIC WORKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WATT CARR ANNA SCOTT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. 11401 CROSS ROAD TRAIL MARGARET BROWN / DAUGHTER BRANDYWINE, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 09-05-2008 ALEXANDRIA, VA 21. Signature of Funeral Ser 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD 20746 DONALD R. GRAY Inter the disease, or or heart failure. List o molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 5 YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a.n., reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi Due to (or as a consequence of): attending physician Physician/Medical as the for use IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed Box 68760, P.O. Records, Division of Vital

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

the has been certificate After this the Hospital or Attending hin 24 hours after deatl the Funeral Director: filled in by the ٥

State Registrar

Medical

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D45365

SEPTEMBER 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701 LIVINGSTON ROAD #101 FT. WASHINGTON, MD MICHAEL SIDAROUS

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of certifier



| | | | For State Registrar | State of | Marylan | • | artment of F ctificate of I | | Mental Hyg | iene eg. No.20 (| 08 28950 |
|----------|---|------------------|---|--|-----------------------------------|----------------------------------|---|--|---|--------------------------------------|---|
| | | | Decedent's Name (First, Middle, Li | ist) | | | | | 2. Date of Deat | th | 3. Time of Death |
| | Physicia /Medic | | James Carl | Give | ns | | | C | Month SEPTEMBE | Day C | Year 2008 09:55A ^M |
| | Examin | | 4a. Facility Name (If not institution, gi | /e street and num Medica | al Cen | iter | 4b. City, Town, or | Location of Death | | 4c. County of | Death Saltimore |
| | Funeral Director | | | Sex 7 1 🔀 M 2 🗆 F | 7. Age (In yrs.) 54 | la <i>st birthd</i> ay) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 02/06/] | Year) 1954 | 9. Birthplace <i>(State or Foreign Country)</i> Maryland |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c Cit | y, Town or Loc | ration | | | | 10d. Inside City Limits |
| | Maryla f sho | ō | | | | | Jan 1911 | | | | 1 ☐ Yes 2 ☐ No |
| | the N | rect | MD Baltimo 10e. Street and Number | re | Dur | ndalk | 10f. Zip Code | | 1 | 0g. Citizen of Wh | nat Country? |
| | h with | Funeral Director | 2713 Southbrook | Rd. | | | 21222 | | | US. | A |
| | ems; | ner | 11. Marital Status | 12. Was Deced | lent Ever in U. | S. 13. V | Vas Decedent of H | ispanic Origin? (S | pecify Yes or No- o Rican, etc.) | | - American Indian, White, etc. |
| 20 | s after | by Fu | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 □Yes 2 If Yes, Give | 2 X No | 1 | □Yes 2⊠No | Specify: | | Specify: | White |
| 12-003p | tura! | ed k | 15. Decedent's E | Year or Dat | ies: | 16a. Decec | lent's Usual Occup | ation | | 16b. Kind of Busi | |
| <u>ດ</u> | hin 72 e. an "ne Media | plet | (Specify only highest gr Elementary/Secondary (0-12) | ade completed) College (1-4 | 4or 5+) | (Give life. L | kind of work done o OO NOT use retired | during most of wor l) | king | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| 7 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show thit, the Medical Exercine rout by notified at | Completed | 12 | | | Carpe | nter | | | Constru | |
| yland | be file ntal H ed oth | Be | 17. Father's Name (First, Middle, Las Marvin | Givens | | | | 18. Mother's Nan Bertie | ne (First, Middle, M | Maiden Surname) Wal | |
| Š | thould nd Me mark matic | 우 | 19a. Informant's Name/Relationship | | | 19h Mailin | g Address (Street | | iral Raute Number | | |
| 2 | nd 2 saith ar 27 is rr trau | | Frances R. Given | | | 1 | Southbr | | | | nd 21222 |
| Jre, | of Head | | 20a. Method of Disposition | · | 1 0 | Place of Dispos | sition (Name of natory or other place | 1 | | | ity or Town, State |
| Ē | Page ment ant; II | | 1 Burial 2 TCremation 3 Donation 5 Other (Special | | tate | | | i i | 12/2008 | Towson, | Maryland |
| baltimol | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiurry or other traumatic event, the Medical Experience and by notified at once. | | Funeral | Home of Dundalk | | | | | | | |
| _ | 40 = 6 G | | 23a. Part 1 Enter the disease, or con | anlications that ca | used the death | | 922 Wise | | undalk, N | - | 2 Inc. |
| | Dhusisian | | shock, or heart failure. List only | one cause on eac | ch line. | | | g, such as cardiac | or respiratory arre | esi, | Interval Between Onset and Death |
| · Sec. | Physician /Medical | | disease or condition resulting in death) | a | HAGEAL | | ER | | | | |
| | Examiner | | Communication to the same distance | b | | | | | | | |
| | \$\\/# | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (o | r as a consequ | uence of): | | | | | 8. |
| | anok | Examiner | that initiated events resulting in death) Last | C | r as a consequ | uence of): | | | | | |
| 0/00, | ficate be executed physician and stransit sthe burial-transit | dical E | | 4 | | | | | | | |
| | tificating phy as the | fedic | | . u. | | | | | | 1 | |
| y. DOX | Attending Physician: The law requires that the death certif ra death, ar death, ar death, After this certificate has been signed by the attending cetor. After this certificate has been signed by the funeral director, page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | | rth 2 ☐ Fetal ant at time of d | Ideath 3□ | Ectopic pregnanc Other (specify) | 4 | | 23d. Date Mont | of delivery h Day Year |
| Ċ | hat the | Phy | 9 ☐ Unknown Part II. Other significant conditions | | | ulting in the un | derlying cause give | an in Part I | 23e Did toh | nacco use contrib | oute to the cause of death? |
| oids, | uires ti signe d be c | d b | SEPSIS | John Bulling to dea | un bui not rest | anng in the un | denying cause give | sii iii Fait i. | 1 □ Ye | 1/ | Probably 4 ☐ Unknown |
| 5 | w requi | Completed | RENAL FAILURE | | | | | | 24a. Was ar | $\overline{}$ | ere autopsy findings available |
| ב | The law te has age 2 t | omo | | D.E. | | | | | autops perforn | y pri ned? de | or to completion of cause of ath? |
| g | hysiclan: The Is his certificate ha I director, page 2 | Be C | HEPATIC FAILU 25. Was case referred to medical examiner? | X.E. | | | | 26. Place of Dea | 1 □ Yes 2 th (Check only one | | □Yes 2K□No |
| > | hysic this ce Il direc | To | 1 Yes 2 No | Hospital: 1 In | patient 2 🗆 | ER/Outpatien | t 3 ☐ DOA Othe | er: 4 □ Nursing H | ome 5 Reside | ence 6 □Other | (Specify) |
| <u> </u> | ding Ph h. After th funeral | | 27. Manner of Death 1 Natural 5 □ Pending | | i Injury , <i>Day, Year)</i> | 28b. Time of Injury | 28c. Injury Work | ? | 28d. Describe ho | w injury occurred | d |
| 2 | Attend death ctor; y the | ficat | 2 Accident Investigation 3 Suicide 6 Could not be determined | e I 200 Diago o | f Injury - At ho | me, farm, stre | M 1 □ | Yes 2 □ No | 28f. Location (St. | reet and Number | or Rural Route Number, |
| 5 | al or / s after il Dire | Certification: | 4 ☐ Homicide determined | building | g, etc. '(Specif) | y) . | 7, | | City or Town | | or ridia riodic ridingor, |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu | Medical (| 29a. Certifier 1 Certifying P (Check only one) Medical Exa | hysician: To the bas miner: On the bas and manne | sis of examina | wledge, death tion and/or inv | occurred at the tir restigation, in my o | ne, date and place pinion, death occu | , and due to the carred at the time, da | ause(s) and man ate and place, an | ner as stated. and due to the cause(s) |
| | Vithi Comp | ž | 29b. Signature and title of certifier | (| 0 | w | 29c. License | number | 25 | | (Month, Day, Year) |
| | 7 | | Kichard | L_ hi | thice | t U-L | - D318 | 26 | | 9-8 | -08 |
| | H | | 30. Name and address of person who | | | | , | | | | |
| | Stat | te | 31. Date filed (Month. Day. Year) | THICUM, | gistrar's Signal | 76211 ture | OSLER | DRIVE | TOWSON, | MARYLA | ND 21294 |
| | Registra | | SEP 1 0 200 | 5 Alexander | e & | Apart | م | | | | |
| | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2004 harles /Medical non 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bath 8. Date of Birth Month, Day, ial Security Number Under 1 Year 9. Birthplace **Funeral** Min. 1**№** M 2□ F P 240-03-7919 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Woolver Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □ Yes 2.5 No f Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cemen -Oreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe 1 ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau 21215 5704 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location 1 ☐ Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 1701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardio Vasco Due to (or as a consequence of) /Medical Examiner Sequentiary net conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? director, Be (26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

mon of in

MAREM 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Macan

501D0 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

ORIGINAL

08-06188 Maryann Grinier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day August 13, 2008 0920 hrs Medical Examiner Maryann Grinier 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 908 Exeter Hall Road Baltimore If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or unk 5. Social Security Numbeunk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director 60 May 4, 1948 2 X F Country) M Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No 28a-f show Baltimore MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene. Important: [fitem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at ource. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 908 Exeter Hall Road unk Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married No Yes If Yes, Give Year Yes 2 X No specify: white Specify: Widowed Divorced \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 23 Nated Adastoffy Moard 655 W. Baltimore Street we of what all dice we le pirector 21201 Baltimore, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED by the attending physician ached for use as the burial Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✓ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death performed? ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this Inpatient 2 1 V Yes ٩ After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Pending 24 hours after death. Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be within 24 hours at To the Funeral D determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2008 30. Name and address of person who dempleted cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (MoSEP)

Registrar DHMH 17 Rev 1/2001

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OCME

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sept. 8, 2008 7:30 p Harry Μ. Gamber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 4431 Worthington Avenue **Glyndon** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□F 77 Director 212-28-7212 Sept 13, 1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examiner myst be notified at Director 1 ☐ Yes 2 No MD Baltimore **Glyndon** filed within 72 hours after death with the l Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4431 Worthington Ave. 21071 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Machinist George Moore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William Gamber Isabelle Crunkilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4431 Worthington Ave., Glyndon, MD 21071 Mary B. Gamber Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Carroll Cremation 9/13/08 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road 200 Le Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** UNI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a nonsequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours.
the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 9 - 9 - 929b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Balt 2/204 45 31. Date filed (Month, Day, Year) 32. Signature State SEP 10 Registrar

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ORIGINAL

| | | 4 | For State | State of Ma | ryland / | | rtment of H tificate of L | | | | | 289 | 154 |
|----------------------------|--|----------------|--|--|----------------|---------------------------|--|---------------------------------------|---|-----------------------------|--------------------------------|---------------------------------------|-------------------------|
| | | | Registrar | | | Cer | illicate of L | Jeani | 2. Date of De | Reg. No. | | 3. Time of | |
| | Physicia | ın | 1. Decedent's Name (First, Middle, Last) | | | | | | Month | Day | Year 200 | 0 1.09 | p M |
| | /Medic | | Euelyn Tłogki 4a. Facility Name (If not institution, give s | imat and numbers) | | | 4b. City, Town, or | Location of Dea | SEPTEM | | County of Dear | | |
| 18 | Examin | er | Genesis Tramey | | | | - | mice | | h! | DX . | | |
| - | Francis | | 5. Social Security Number 6. Sex | | (In yrs. last | birthday) | If Under 1 Year | If Under 24 Hrs | | rth | 9. Bir | thplace (State country) | r Foreign |
| | Funeral Director | | 218-01-0220 |]М Ж Е | 91 | Yrs. | Months Days | Hours Mir | |)-191 | | MD_ | |
| | | | Usual Residence of Decedent | | | | | | | | | 10d. Inside Ci | ty Limite |
| | inylan show | _ | 10a. State 10b. County | | 10c. City, To | | | | | | | 1 ⊋ Yes | ' |
| | Ba-f s | 용 | MD N/A | | Balt. | lmor | | | | 10a Citiz | en of What Co | 22 | |
| | or 2 | Director | 10e. Street and Number | | | | 10f, Zip Code | | | Tog. Citiz | en or winat of | outing: | |
| | s 23a | la l | 4614 Elsrode Av | enue 12. Was Decedent E | ver in LLS | 13 1 | Vas Decedent of H | | Specify Yes or N | | S A 4. Race - Ame | erican Indian, | |
| | er de item | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Armed Forces? | | 13. | Vas Decedent of H Yes, specify Cuba | an, Mexican, Pue | erto Rican, etc.) | | Black, Whi | | |
| 36 | be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at | | 3 ▼Widowed 4 Divorced | 1 ☐ Yes 2 😿 N If Yes, Give 🔀 Year or Dates: | | 1 | ☐ Yes 2 No | Specify: | | | Specify: B | lack | |
| Ş | 2 hou atura cal E | Completed by | 15. Decedent's Edu | cation | 1 | 16a. Deced | ent's Usual Occup | ation | varking | 16b. Kin | d of Business | /Industry | - 1 |
| 715 | nin 7% In "n Medi | ple | (Specify only highest grade | College (1-4or 5- | +) | life. L | kind of work done of NOT use retired | danng most or w d) | Urking | | | | |
| 2 | d with | E O | 10th grade | N/A | <u></u> | Di | sabled | | | | sable | d | |
| b | al Hy I othe | Be (| 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's N | ame (First, Middl | e, Maiden S | Surname) | | |
| <u>a</u> | | ٩ | Gary Davis | | - | | | Elino | | | | | |
| Maryland 21215-0036 | 2 should be filed v and Mental Hygie Is marked other t raumatic event, th | 23. 3 | 19a. Informant's Name/Relationship (Ty | | 12 | | g Address (Street | | | | | | 1 |
| | 日申には | | Elinor Annis-N | 1ece | 20h Plac | | Loch | | Date E | Balto | o, MD | 21239 Town, State | |
| 0 | 00- | | 20a. Method of Disposition 14 Burial 2 □ Cremation 3 □ F | | 1 | | sition (Name of natory or other place | 1 | 12 2000 | | | | |
| Baltimore, | it. Pa rtmer rtant: njury | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens | | Arbi | | Mem Pa | | 12-2008 | 1 | | MD | |
| Ba | permit. Pag Department Important: i any injury o | | 1 Dladono | Wan | | | 1101 E | . Nort | March h Avenu | ie B | alto, | | 202 |
| | 73.8 | | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only o | ications that caused ne cause on each lin | the death. | Do not ent | er the mode of dyi | ng, such as card | iac or respiratory | arrest, | | Approxima Interval Be Onset and | te tween |
| 4 | Physician | ni, d | Immediate Cause (Final disease or condition | ASCUS | | | | | | | | 4es. | |
| | /Medical | | resulting in death) | Due to (or as | a consequer | nce of): | | | | | | , | |
| | Examiner | _ | Sequentially list conditions, | b | | naa afi: | | | | | | | |
| 7 | ed sit | ine | if any, leading to immediate cause. Enter Underlying | Due to (or as | a consequer | nce or). | | | | | | | |
| 75 | and and | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | C Due to (or as | a consequer | nce of): | | | | | | | |
| 8760, | cate be executed physician and transit | dical E | | d | | | | | | | | | |
| 687 | ficate j phys | edic | | u | | | | | | | | | |
| Box | eath certific attending p for use as | 2 | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome 1□Live birth | | |]Ectopic pregnanc | 27 | | 1 2 | 23d. Date of d | | V |
| Ď. | The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4□Pregnant at | | | Other (specify) | , | | | Month | Day | Year |
| P.0. | w requires that the de been signed by the should be detached | hys | 9 ☐ Unknown | | | | | | 00 D | 4.4-1 | | to the cause of | donth? |
| S, | es tha | | Part II. Other significant conditions co | | ut not resulti | ing in the u | nderlying cause gi | ven in Part I. | | | _ | Probably 4 | |
| bro | equir sen s | B | Chronic rent | distore | | | · - | | - " | | | | |
| ec C | has be | Completed by | dementa | | | | | | _ 24a. Wa | as an topsy rformed?_ | 24b. Were prior to death? | autopsy findings completion of | s available cause of |
| <u>=</u> | The cate h | 00 | | | | | | | | 2 No | | s 2□No | |
| Vita | iclan Sertific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | Otl | | Death (Check onl | | | | |
| O | Phys this al dir | 5 | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 1 ☐ Inpatie | | R/Outpatie 28b. Time o | | | g Home 5 ☐ Re | | | ecity) | |
| Division or Vital Records, | ding I. After funer | ion | 1 ☑Natural 5 ☐ Pending | (Month, Da | | Injury | Wa | irk?]Yes 2∐No | | , | • | | |
| isi | Atten deatl ctor: y the | fica | 3 Suicide 6 Could not be | | | e, farm, st | reet, factory, office | | 28f. Location | Street an | d Number or | Rural Route Nu | mber, |
| <u></u> | alor safter al Dire d in b | Certification: | 4 Homicide | building, et | c. (Specify) | | | | City or | omi, State | | | |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page: | edical C | (Check only 2 Medical Exam | /sician: To the best | f examinatio | ledge, dea on and/or i | th occurred at the to | time, date and pl opinion, death o | ace, and due to to occurred at the tin | he cause(s ne, date an |) and manner d place, and d | as stated. ue to the cause | (s) |
| | o the ithin 2 o the omplei | Med | 29b. Signature and title of certifier | and manner st | | | | se number | | | te signed (Mo | nth, Day, Year) | |
| | FSFö | | | completed cause of completed cause of completed cause of completed cause of complete cause of cause of cause of cause ca | | | D | 31295 | | 90 | 15/08 | | |
| | n | 1 | 30. Name and address of person who | completed cause of c | leath (Item 2 | 23a) (Type | Print) | 7 ' | آلاً: م. | | | | |
| | 3 | 1 2 | 1 100,000 | 5701 K | chwo | is of | Ave 13 | salh mund | e ma | - 5 | 21206 | | |
| | | ate | 31. Date filed Month, Day, Year) SEP 1 0 2008 | 32. Registi | ar's Signatu | ire OCA | W | | | | | | |
| | Regist | rair | OLL TO FOOD | A . | • | - | | | ···· | | | | |

Baltimore, Maryland 21215-0036

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Physician /Medical Examiner

P.O. Box 68760, Division of Vital Records,

4a. Facility Name (not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Rida 0 pr 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Date of Birth (Month, Day, Months Days Hours 1 □ M 2 🔽 F 88 422-05-8759 Feb 13 Director 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show avin injury or other traumatic event, it e Modical Examiner man be a coffied at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Carroll Sykesville 1 ☐ Yes 2 ☐ YNo Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 710 Obrecht Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2√ No If Yes, GiveA Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roger Conbel Annie Wolcott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Lynn Hoff (co-executor) 1013 Orchard Dale Dr., Sykesville, MD 21784 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 9-10-08 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage Saight P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Was ar. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 💋 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifig 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 Ton 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

2. Date of Death

September

3. Time of Death

2008

| | | | For State Registrar | State o | of Marylar | | artment of F rtificate of I | | | giene , Reg. No. 4 | 711118 | 28956 |
|---|--|------------------|--|--|----------------------------------|-----------------------|---|----------------------|-------------------|-----------------------|---------------------------|--|
| | - · · · | | 1. Decedent's Name (First, Middle | Last) | | | | | 2. Date of De | eath | Year | 3. Time of Death |
| | Physici: /Medic | | JAMES HEKTI | VER | | | | | September | Day | 2008 | 1958 PM |
| | Examin | er | 4a. Facility Name (If not institution, | - | | | | Location of Death | , | 4c. C | County of Death | 1 |
| | F | | JOHNS HOPKINS BAYVIE 5. Social Security Number | MEDICAL 6. Sex | 7. Age (In yrs | | BALTIMOR If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir | rth | 9. Birth | nplace (State or Foreign |
| | Funeral Director | | 721.18.7414 | 1 M 2 □ F | 81 | Yrs. | Months Days | Hours Min. | (Month, Da | ay, Year) | Col | untry) |
| | pu , | | Usual Residence of Decedent | | | | | | | | | |
| | arylat show | 7 | 10a. State 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | 10d. Inside City Limits |
| | the M | recto | NY SUFFOL 10e. Street and Number | K | Н | UNTINGTO | N 10f. Zip Code | | | 10a Citiza | en of What Cou | 1 Yes 2 No |
| | death with the Maryland ims 23a or 28a-f show r must be notified at | Ī | 3 COON HOLLOW RD | | | | 11743 | | | 109. 0112 | USA | ullay. |
| | death | Funeral Director | 11. Marital Status | 12. Was Dec | edent Ever in U | | Was Decedent of H | lispanic Origin? (Sp | pecify Yes or No |)- 14 | 4. Race - Amei | |
| õ | filed within 72 hours after Hygiene. ither than "natural", or ite ant, the Medical Examire | | 1 Never Married 2 Marri | ed 1 Yes If Yes, Gi | orces? | | If Yes, specify Cuba 1 □Yes 🕷 No | Specify: | o Rican, etc.) | | Black, White | , etc. |
| 2-003e | hours ural", | od by | 3√√ Widowed 4 □ Divorced | Year or D | | | | | | | Specify: WHIT | |
| 2 | in 72 n "nat | Completed | 15. Decedent' (Specify only highest | grade completed) | | (Give | dent's Usual Occup kind of work done o DO NOT use retired | during most of work | king | 16b. Kind | d of Business/I | ndustry |
| 7 | d with giene gr thau | Com | Elementary/Secondary (0-12) | College (| | ELE | CTRICAL ENG | INEER | | AV | IONICS | |
| B | 2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M | Be C | 17. Father's Name (First, Middle, L | ast) | | | | 18. Mother's Nam | ne (First, Middle | , Maiden S | urname) | |
| yıand | should be tand Mental s marked o umatic eve | 2 | GEORGE HEKTNER | | | | | ANNE SOM | MERFELD | | | |
| = | 12 sh h and 7 is m traum | | 19a. Informant's Name/Relationsh | ip (Type. Print) | | | ng Address (Street | | | | Town, State, Z | (ip Code) |
| | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expriner must be notified at | | SUSAN TERLEP 20a. Method of Disposition | | 20b. | 1170 | | | Date | | Fown, State | |
| | | | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | State | - | esition (Name of natory or other place EMATORY INC | | | | MCRE, MD | own, outo |
| Dalt | permit. Page Department of Important; If any Injury or once. | | 21. Signal of Superal Bertice L | | | 1/2 | 2. Name and Addres | ss of Facility | - | | | |
| Ď | Depar Impor any Ir | 0 | K, GREGORY EII | NK T | MO: | | INK FUNERAL 26 CRAIN HW | | | | | SUPPORT |
| | | | 23a. Part 1. Enter the disease, on shock, or heart failure. List | on plications that only one cause on e | caused the dea | th. Do not en | ter the mode of dyin | ng, such as cardiac | or respiratory a | ırrest, | | Approximate Interval Between |
| May F | Physician | H | Immediate Caus (Final disease or condition | seps | | | | | | | | Onset and Death Will Oxide Let 2 days |
| 1 | /Medical Examiner | | resulting in death) | Due to | (or as a consec | quence of): | | | | | | 41 10 40 / 2 11 / 1 |
| | -xanimoi | <u>ا</u> | Sequentially list conditions, if any, leading to immediate | D | (or as a consec | unana afti | | | | | | approximately I month |
| | nsit / | min | cause. Enter Underlying Cause (Disease or injury that initiated events | Due to | (or as a consec | querice oi). | | | | | | |
| 'n | exection and and all all tra | Examiner | that initiated events resulting in death) Last | c | (or as a consec | quence of): | | | | | | |
| 00/0 | ficate be executed physician and street the burlal-transit | edical | | d | | | _ | | | | | |
| 9 | To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Med | IF FEMALE: | | | | | | | | | |
| Š | eath certific attending p | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 1 Live | tcome of pregn birth 2 ☐ Feta | al death 3[| Ectopic pregnanc | y | | 23 | Bd. Date of deli Month | very Day Year |
| 5 | the de | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Preg 9 ☐ Unkr | nant at time of nown | death 51 | Other (specify) _ | | | | | , |
| _ | that the post of t | | Part II. Other significant condition | s contributing to d | eath but not res | ulting in the u | nderlying cause glv | en in Part I. | 23e. Did 1 | tobacco us | e contribute to | the cause of death? |
| cords, | quires in sign | d by | | | | | | | 1 🗆 | Yes 2 | No 3□ Pro | obably 4 Unknown |
| 5 | aw red | Completed | | | | | | | 24a. Was | | | topsy findings available |
| ֓֞֞֝֟֞֜֞֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֓֡֓֡֓֡֓֡֡֡֡֡ | The late ha | mo: | | | | | | | auto perfo | rmed? | death? | completion of cause of 2 □ No |
| 3 | ertifica ctor, p | Bec | 25. Was case referred to medical examiner? | | | | | 26. Place of Deat | | | 1 🗆 163 | 2 |
| 5 6 | hysic this co | 2 | 1 Yes 2 No | | Inpatient 2 | | | 4 LI Nursing H | ome 5 Resi | idence 6 | □Other (Spec | pify) |
| | ding Physician: The n. After this certificate h. funeral director, page | ioi | 27. Manner of Death 1 Natural 5 □ Pending | | of Injury th, Day, Year) | 28b. Time o Injury | Work | | 28d. Describe | how injury | occurred | |
| <u>.</u> | death death ctor: y the | ficat | 2 Accident investiga 3 Suicide 6 Could no | t be | of Injury - At h | ome, farm, str | M 1 □ | Yes 2□No | 28f Location / | Stroet and | Number or Ru | ral Route Number, |
| 5 | after Dire dinb | Certification: | 4 ☐ Homicide determin | | ing, etc. (Speci | | oot, 140tory, 011100 | | City or To | wn, State) | rvaniber of tra | an i iodie ivamber, |
| | ospita hours inera ly fille | - 1 | 29a. Certifier | Physician: To the | best of my kn | owledge, deat | h occurred at the tir | ne, date and place | , and due to the | cause(s) a | and manner as | stated. |
| - | the Hin 24 the Full 124 the Ful | Medical | one) | and man | ner stated. | ation and/or in | vestigation, in my o | pinion, death occu | rred at the time, | date and p | olace, and due | to the cause(s) |
| ŀ | 7 with | 2 | 29b. Signature and title of certifier | bal | | | 29c. License | | | _ | signed (Month | |
| | 1 | | | | | | | 5-000 | | septe | mber 2 | , 2008 |
| | 12 | | 30. Name and address of person was JOYCE M. KOH | | | | | DRE MO | 71776 | + | | |
| A symp | Sta | te | 31. Date filed (Month, Day, Year) | | legistrar's Signa | ature | | ,,,, | - 00 | 1 | | |
| | Registra | ar | SFP10 | 2008 | Suga A | y So | will ! | | | | | |

| | | Plea | se Type or | | | | | | | | I Copies | | _ | | |
|--|-------------------|---|---|---------------------------|-------------------------|---------------------|---|------------------------------|--------------------------|-------------------|---|-------------------------|--|--|-------------------------------|
| | | 1 - For State Registrar | State | JI IVIAI | ylanu / | • | tificate | | | and iv | ieniai riy | Reg. No | 2000 | 3 2 | 8957 |
| | 9 | Decedent's Name (First, Middle) | e, Last) | | | | | | | | 2. Date of De | | E | 3. Tim | ne of Death |
| Physic /Med Exami | ical | Alice Geraldine 4a. Facility Name (If not institution 3112 River Driv | , give street and n | | | | 4b. City, 1 Edge | | | | | per | 8, 2008 c. County of Dea Baltimo | | 15 a ^M |
| Funera Director | | 5. Social Security Number 213-34-6175 | 6. Sex 1 □ M 2 🔀 F | 7. Age | (In yrs. last L | birthday) . Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bi (Month, D | ay, Year |) (| thplace (St ountry) | ate or Foreign |
| 70 | | Usual Residence of Decedent | The contract | | | | | | | 02-08- | -193 | | | | |
| ne Maryla 8a-f shov | ector | Maryland Baltim | ore | | Edgem | | | | | | | | | 1 🗆 | de City Limits Yes 2 🙀 No |
| with the | Dir | 10e. Street and Number | | | | | 10f. Zip | | | 31 | | 10g. C | itizen of What C | ountry? | |
| ter death | Funeral Director | 3112 River Dri 11. Marital Status 1 □ Never Married 2 Marr | 12. Was Dec | | | 11 | f Yes, spec | ent of His ify Cubar | spanic Ori n, Mexicar | igin? (Spo | ecify Yes or No Rican, etc.) | | ted Stat 14. Race - Am Black, Whit | erican India | n, |
| ours af | þ | 3 Widowed 4 Divorced | If Yes, G Year or | ilve | | 1 | □Yes 2 | No P | Specify: | | | | Specify: Wh | ite | |
| and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Mental Hygiene. It has 23a or 28a-f show other traumatic event, the Wadral Event in the traumatic event, the Wadral Event in the traumatic event. | Completed | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | st grade completed |) (1-4or 5+) | - | (Give I | lent's Usua kind of wor OO NOT us | k done di | uring mos | t of worki | ng | | Kind of Business | /Industry | |
| filed v Hygie other t | | 12 17. Father's Name (First, Middle, | O Last) | | | omema | aker_ | | 18. Mothe | er's Name | (First, Middle | | | | |
| uld be Mental arked o | To Be | Foster Boggs | | | | | Ida Wright | | | | | | | | |
| 2 sho h and rs ma raums | | 19a. Informant's Name/Relationship (Type. Print) Thurman G. Hoffman (Husband) | | | | | ailing Address (Street and Number or | | | | | | | | |
| 1 and 1 and Health Hem 27 | | 20a. Method of Disposition | man (Hus | sbano | 20b. Place | of Dispos | sition (Nam | ne of | i | | Edgeme Date | | Maryland | | |
| permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tran | | 1 ☐ Burial 2 € Cremation 4 ☐ Donation 5 ☐ Other (S) | | | ceme | tery, crem | natory or ot | her place | · ; |)9 – 10 | 1-2008 | | son, Mar | | |
| permit. Departn Importa any inju | | 21. Signature of Funeral Service | Licensee | | | 22 | . Name and | d Addres | s of Facilit | ^y Duda | -Ruck | Fune | eral Hom | e of | Dundalk |
| Physician /Medical Examiner | | 23a. P. t1. Enter the dise of nock, or heart fail. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | _aCo | o (or as a | consequence | o not ente | | e of dying | g, such as | | | | lk Maryl | Approx | |
| | 1 | resulting in death) Last IF FEMALE: | d | (or its a c | consequenc 1 | e of): | -b~11 | ate | o~, | | | | | | - |
| at the death ce by the attendi | Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 | | | | | | | | | 23d. Date of delivery Month Day Year | | | | |
| w requires that been signed I should be deta | þ | Part II. Other significant condition | • | death but | not resulting | in the un | derlying ca | use give | n in Part I. | | | | use contribute t | | |
| The lar | Completed | 25. Was case referred to medical | | | | | | | | | | opsy ormed? 2.X.N | prior to | utopsy find completion s 2 \(\sum No | ings available of cause of |
| Physician: this certific al director, | To Be | examiner? | Hospital: |] Inpatient | 2 🗆 ER/0 | Outpatien | t 3 □ DO | A Othe | r: | | n <i>(Check only</i> me 5 ⊠ Res | | 6 ☐ Other (Spe | ecify) | |
| ending Pheath. | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investig | g <i>(Mo</i> lation | e of Injury nth, Day, | | . Time of Injury | M 28 | 3c. Injury Work′ 1 □ Y | at ? ′es 2 🔲 | | 28d. Describe | how inju | ury occurred | | |
| To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Aft completely filled in by the fun | Certification: | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi | nod Zoe, Plac | e of Injury ding, etc. | - At home, (Specify) | farm, stre | eet, factory, | office | | | 28f. Location City or To | (Street a wn, Stai | ind Number or Fi te) | tural Route | Number, |
| the Hospi in 24 hou the Funer ipletely fill | edical | (Check only 2 Medical I | g Physician: To the Examiner: On the and ma | | xamination | | | | | | | | | | ıse(s) |
| 10 times | Σ | 29b. Signature and title of certifier | ^ | (.0 | | | 29c. | License | | | | 29d. D | Date signed (Month, Day, Year) | | |
| Q | | 30 Name and address of person | | se of dea | | | Print) | | 0551 | | Hinor | | 0 1/08 | 12001 | |
| | ate | 31. Date filed (Month, Day, Year) | 32 | | s Signature | | 1-Vh | TIVE C | nue | 170 | TYTHON | | riva | 1 24 | r |
| Regist | irar | 251.10 | 2000 | Turn Bert | S | HOW | A SA | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 1, 2008 5:15 PM M Khalil Holloway-Laney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Hospital Prince George's Southern Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months 1 X M 2 □ F Director Sept 1, 2008 infant Maryland Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventimes must be notified at 1 ☐ Yes 2√ No Director MD Prince George's Suitland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20746 3401 Pearl Drive #1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 1 ☐ Yes 2 📉 No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Korvette Holloway Ryland Laney ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD 20735 19a. Informant's Name/Relationship (Type. Print) Southern Maryland Hospital Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State in state 4 Donation 5 MOther (Specify) 21. Signature of Funeral Secuce Licenses State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ouse (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Let underly g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Euneral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 10 29b. Signature and fitle of certifier 29c. License number 5/1/08 ess of person who completed cause of death (Item 23a) (Type, Print) Clinton MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 31, Day 2008 **Physician** 3:45 PM M Eugene Hill /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hyattsville Heartland Health Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F 259-22-5621 May 4, 1925 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show r 28a-f shov notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Capitol Heights 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 4600 Omaha Street 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: black 1 ☐ Yes 2 🛛 No Specify: <u>۾</u> 3 Widowed 4 Divorced Completed unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If item 27 is marked other than ury or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event. unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannie Ellison/sister 1504 Beaver Heights Lane Capitol Heights, MD 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Important: If any Injury or 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 5 NOther (Specify) in state 4 ☐ Donation 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2 1 No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 003 Division or Vital Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 6

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Lecknill

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Kando

State Registrar 31. Date filed (Month, Day, Year) 10 ŜEP 2008

NOMEN

29b. Signature and title of certifier

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

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29d. Date signed (Month, Day, Year)

HANOVER STREET BALTIMUZE MD.

Registrar

D° 2008

32. Registrar's Signature

ORIGINAL

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

per MD 9883 9/25/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No UUB Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** TACKSON Annie Marie Jackson septembel ob 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON HOSPICE GILCHRIST If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🗹 F JANUARTIS, 1916 MARTLAND Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21204 WEST 23a ROAD Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or Items 12. Was Decedent Ever in U.S. 11. Marital Status Anned Forces?
1 ∐Yes 2 No
If Yes, Give
Year or Dates: Armed Force 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 þ BLAC 3 Widowed 4 Divorced "naturai" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) FOOD CATERER 13 th and Mental Hygie 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE JACKSON ころろろろろう 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Closwa RODD BALTIMORE MD 21215 GEORGE JACKSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIPTS PLLISTRY ISTITEMBLE 10, 2001 HANDUND MARTILLAN 4 Monation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7522 CONNELLEY DR. STE P. HAVAKE MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HYPOXIA day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DEMENTIA the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ECUBITUS 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury 28a. Date of Injury (Month, Day, Year) occurred After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. i Director: d in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0910 ner Mo W. Towsaltown Dalford 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Sept 5, 2008 **Physician** 3:40 P Jesse M. Jones, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 15, 1939 VA Rehab & Extended Care Center Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 🗓 📈 2 🗆 F 241-52-0536 GA **Director** 69 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show other traumatic event, the Wedical Examiner rust be notified at 1 ☐ Yes 2XXNo Director Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or filed within 72 hours after death with # A 21061 USA 7775 New York Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ Yo or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify If Yes, Give Specify: White Completed by 3 Widowed 4 Divorced Year or Dates "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army United States Government 12 1 and 2 should be filed w Health and Mental Hygie 3**m 27 is marked other** t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ Bessie Stone Jesse M. Jones, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i 606 Pontiac Ave, Baltimore, MD Carol Bowen Friend 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 Other (Specify) Crownsyille Veterans Cem | Sept 9, 2008 Crownsville, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Fink M01148 426 Crain Hwy, S, Glen Burnie, MD Approximate Interval Between Onset and Death 23a. Part 1. Exter the disease, or shock, or heart fa ure. List or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final **Physician** SMALL CELL LUNG CANCER YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death), act Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? λq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 2 XX10 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: MKI Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2xx No 1 Inpatient 2 ER/Outpatient 3 DOA cal Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury 1 XXVatural 5 Pending neral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56508 SEPT 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIANGRING SHAO 3900 LOCH RAVEN BLVD BALTIMORE, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Box 68760

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Division of Vital Records,

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| | 55 E | il. | Registrar 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | | | | | |
| | Physici | | Alan Donald Jung | | | | | Septem | ember 3,2008 11:40 AM | | | | |
| | /Medic Examir | | 4a. Facility Name (If not institution, give s. | treet and number) | | 4b. City, Town, or | r Location of De | | 4c. County of Death | | | | |
| | | | Carroll Hospital | Center | | Westm | inster | | Carr | :011 | | | |
| * | Funeral Director | | 5. Social Security Number 6. Sex | | n yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | | in. 8. Date of Birth (Month, Day July 5, | 1930 | 9. Birthplace (State or Foreign Country) Maryland | | | |
| MEA | p. | | Usual Residence of Decedent | · · · · · · · · · · · · · · · · · · · | 0. 7 | | | | | Land to the continue | | | |
| | arylar show dat | _ | 10a. State 10b. County | 10 | c. City, Town or Lo | | | | | 10d. Inside City Limits 1 □Yes 2 □ No | | | |
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| | vith the | Director | 10e. Street and Number | | | 10f. Zip Code | 1157 | | 10g. Citizen of V | • | | | |
| | s 23a | -gra | 201 St. Mark Way | 2 Was Danidant Fue | - :- !! 6 40 } | | | (Cassify Vac or No | USA | e - American Indian, | | | |
| 39 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 15 | | was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No | an, Mexican, Pu Specify: | (Specify Yes or No- uerto Rican, etc.) | Blac | c.white | | | |
| ŏ | 2 hor | Completed | 15. Decedent's Educ | ation | 16a. Deced | dent's Usual Occup | ation | varleina | 16b. Kind of Bu | usiness/Industry | | | |
| 泛 | hin 7 e. an "n Med] | ed be | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. L | kind of work done DO NOT use retired | during most of v d) | working | | | | | |
| 7 | d wit | Š | 12 | <u>5+</u> | | dentist | | | healt | | | | |
| 9 | al Hy al Hy I oth | Be (| 17. Father's Name (First, Middle, Last) | | | | | Name (First, Middle, | | | | | |
| <u>a</u> | Ment Ment arked | <u>ا</u> وا | Conrad Edward Jur | ng | | | Elsie | e Irene Ve | nDouern | | | | |
| Mar | and 2 sho alth and 27 Is ma er trauma | | 19a. Informant's Name/Relationship (Type Katherine Jung/spo | | | | | Rural Route Number, Stminster, | | State, Zip Code) 157 | | | |
| Baltimore, Maryland 21215-0036 | Pages 1 anent of He ant: If item ury or oth | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State | | | | | | | | | | |
| Balt | permit. Departi | | 21. Signature of Euneral States Sicense | as Trec | | Name and Addre tate Anat altimore, | _ | | Baltim | ore Street | | | |
| pt i | | | 23a. Par 1. Enter the disease, or complice shock, or heart failure. List only on | cations that caused the e cause on each line. | | | | | rest, | Approximate Interval Between | | | |
| | Physician | | Immediate Cause (Final disease or condition | 1.3 | Shoc | A | | | | Onset and Death | | | |
| \mathcal{L} | /Medical | | resulting in death) | | onsequence of): | | .0 / | 2 01 6 | | | | | |
| 6 | Examiner | | Sequentially list conditions | Clostru | duum | Diffic | cile (| Colitis | | | | | |
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| | ecute and trans | Examiner | Cause (Disease or injury that initiated events c. resulting in death) Last | | | | | | | | | | |
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| 8760, | icate be executed physician and s the burial-transit | dical | d. | | | | | | | | | | |
| Ø × | The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit | Mec | IF FEMALE: | | | | | | | | | | |
| Вох | ath c | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome pf p | Fetal death 3 | Ectopic pregnancy | / | | 1 | te of delivery inth Day Year | | | |
| | the a | /sic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at tim 9□Unknown | ne of death 5 □ | Other (specify) _ | | | | Worth Day real | | | |
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| က် | ires t signe sibe c | by | Cossenas. 1. ast | L 1° | recise | ndonying dadoc giv | cir iii r ait i. | 1 🗆) | / | 3 ☐ Probably 4 ☐ Unknown | | | |
| 0 | w require been signatures | ted | No contract | | | | | | | | | | |
| Records, | ne law has b ye 2 s | Completed by | congestive 1 | fearl 1 | Failur | <u>e</u> | | – 24a. Was autop | sy | Were autopsy findings available prior to completion of cause of | | | |
| | | Š | Atrial Filer | ellation | 1 | | | 1 Yes | | death? 1 ☐ Yes 2 ☐ No | | | |
| Vita | siclan: The certificate har rector, page | Be | 25. Was case referred to medical examiner? | ospital: | | LOth | | Death (Check only o | ne) | | | | |
| ō | di is | မ | I Tes 2 P 140 | 1 Inpatient | 2 ER/Outpatien | | 4 LI Nursin | g Home 5 Resid | | | | | |
| <u>_</u> | ing I | on | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Ye | ear) 28b. Time of Injury | Wor | | 28d. Describe h | scribe how injury occurred | | | | |
| Division or | Attending Physician: r death. ector. After this certifica by the funeral director, i | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | OO - Place of injury | At home form str | | Yes 2 No | 001 1 | | D 10 1 M 1/2 | | | |
| ≥ | or Al fler of Direction by | ij | 4 ☐ Homicide determined | 28e. Place of injury building, etc. (3 | Specify) | eet, ractory, onice | | City or Tou | street and Numb vn, State) | er or Rural Route Number, | | | |
| | pital | | 200 Cortifier 150 Continue China | ician: To the best of = | ny knowlodae do-4 | h oppured at the 41 | ma data and it | and thus to the | nguno/=\ | apper on state # | | | |
| | To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral | edical | 29a. Certifier 1 Lectifying Phys (Check only one) 1 Medical Examin | iclan: To the best of n er: On the basis of ex and manner stated | amination and/or in | vestigation, in my o | opinion, death o | ace, and due to the courred at the time, | date and place, | anner as stated. and due to the cause(s) | | | |
| | ithin s | Mec | 29b. Signature and title of certifier | and manner stated | | 29c. Licens | e number | | 29d. Date signe | d (Month, Day, Year) | | | |
| | ⊢≯Fŏ | | A. J. Held | RI.M.D. | | Do | 0176 | 95 | Septen | Month, Day, Year) Wer 3, 2008 | | | |
| | | | 30. Name and address of person who cor | | h (Itom 93a) /T | Print) | | | Fich | | | | |
| | | | ABDALLAH J. HELC'L 31. Date filed (Month, Day, Year) | M.D. | | HOSPITA | AL CEN | TER, NEST | MINSTE | ER, MD 21157 | | | |
| | Sta Registr | | SFP 1 0 2008 | J. Heyistidi's | Signature | · A | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28965 State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEP TEMBER 2 12 12 18 12:15FM Elizabeth E. Johnson 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Center Baltimore Towson 8. Date of Birth (Month, Day, Tune 7, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months

88

10c. City, Town or Location

1 □ M 2 🛛 F

Days

Min

1920

10d. Inside City Limits

Hours

/Medical Examiner

220-20-5409

10a. State

Usual Residence of Decedent

10b. County

Physician

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylam Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examine must be notified at any Injury or other traumatic event, the Medical Examine must be notified at any Injury or other traumatic event, the Medical Examine must be notified at any Injury or other traumatic event, the Medical Examine must be notified at any Injury or other traumatic event, the Medical Examine must be notified at any Injury or other traumatic event.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above and ieral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran

Division of Vital Records, P.O. Box 68760,

| 읈 | MD | Ва | 1timore | | | | | | fX Yes 2 ∐No | | | |
|--|--|---|---|---|--|---|---|---------------------------------------|--|--|--|--|
| ě | 10e. Street and Number | | 10f. | Zip Code | | | 10g. C | itizen of What Co | untry? | | | |
| Funeral Directo | 1717 N. Payson St | reet | | USA | | | | | | | | |
| , | 11. Marital Status | Was Decedent Ever in U.S. | 13. Was De | 14. Race - American Indian, Black, White, etc. | | | | | | | | |
| | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 | 1 | s 2 K ÍNo | | o riioan, etc., | | Specify: b1 | | | | |
| 1 | 3 X Widowed 4 □ Divorced | Year or Dates: | | | opeany. | | | эреспу. — — | | | | |
| | 15. Decedent's Educa (Specify only highest grade | | 16a. Decedent's U (Give kind of | Jsual Occup work done | oation during most of world) | king | 16b. I | Kind of Business/ | Industry | | | |
| combiered by | Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | | ucato | | | edı | education | | | | |
| 2 | 17. Father's Name (First, Middle, Last) George Witt Evans | | 18. Mother's Name (First, Middle, Maiden Surname) Willerma Holt | | | | | | | | | |
| 2 | | 19a. Informant's Name/Relationship (Type. Print) Pamela E. Johnson/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Statement 1812 Madison Avenue Baltimore, MD 212 | | | | | | | | | | |
| | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify) | moval from State | e of Disposition (letery, crematory | Name of or other pla | ce) | Date | 20c. l | ocation - City or | Town, State | | | |
| | 21. Signature of Funeral Service Ucensee | ade Derector | State | e and Addre | ess of Facility Omy Board MD 2120 | 1 655 W. | Ва | 1timore | Street | | | |
| | 23a. Part Enter the disease or milities show or heart failure. List inly one immediate use (Final | | rrest, | | Approximate Interval Between Onset and Death | | | | | | | |
| | disease or condition resulting in death) | Due to (or as a consequer | nce of): | | TIC | IN | | | | | | |
| | Sequentially list conditions, if any, leading to immediate ACUTE NON Q-WAVE MYOCARDIAL INFARCTION Due to (or as a consequence of): | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | | | | |
| | resulting in death) Last | chairminated events c. Due to (or as a consequence of): | | | | | | | | | | |
| į | | | | | | | | | | | | |
| combined as in solution and a more discounting | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23d. Date of de Month | | | | | | | | | | |
| | Part II. Other significant conditions contr | ibuting to death but not resulting | ng in the underlyir | ng cause giv | en in Part I. | 23e. Did t | obacco | use contribute to | the cause of death? | | | |
| | ACUTE RENAL FAI | LURE | | | | 10 | Yes 2 | No 3□P | robably 4 🗆 Unknown | | | |
| 1 | DIABETES | | | | | 24a. Was autop perfo 1 □Yes | | 24b. Were at prior to death? | utopsy findings available completion of cause of | | | |
| | 25. Was case referred to medical | | | | 26. Place of Dea | | | | | | | |
|) | examiner? 1 ☐ Yes 2 No | spital: 1 Inpatient 2 ☐ EF | 3/Outpatient 3 ☐ | DOA Oth | ner: 4 🗆 Nursing H | ome 5 Resid | dence | 6 ☐ Other (Spe | ecify) | | | |
| | 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation | | Bb. Time of Injury M | 28c. Inju Wo | ry at | | Describe how injury occurred | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home building, etc. (Specify) | y - At home, farm, street, factory, office (Specify) | | | | 28f. Location (Street and Number or Rural Route N City or Town, State) | | | | | |
| income. | 29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) | cian: To the best of my knowle er: On the basis of examination and manner stated. | edge, death occui n and/or investiga | rred at the tation, in my | ime, date and place opinion, death occu | e, and due to the urred at the time, | cause date a | (s) and manner a nd place, and due | s stated. e to the cause(s) | | | |
| í | 29b. Signature and title of certifier | | | 29c. Licen | se number | | 29d. D | ate signed (Mon | | | | |
| | 1 Com | |) | D 3 | 87254 | | C | 7/3/0 | 8 | | | |
| | 30. Name and address of person who com | pleted cause of death (Item 23 | 3a) (Type, Print) | | | | | | | | | |

State Registrar

completely

BOON FOH

31. Date filed (Month, Day, Year) 008

LIM

7601

32. Registrar's Signature

OSLER

TOWSON MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 amend #8 Per FH G883 9/15/08 JH Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Jackson September 2008 1:30 AM e55e 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 9. Birthplace (State or Foreign atonsville Baltimore Commons If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Pats 4 Big 930 Country) Days Hours Min 1**∑**M 2□ F 218-26-0682 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No N/A Baltimore 10f. Zip Code 21229 Citizen of What Country? 10e. Street and Number USA 1015 Stamford Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Xes 2 ☐ No If Yes, Give Year or Dates1 9 5 7 – 61 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White ctan 1 ☐ Never Married 2X Married 1 ☐Yes 2 XNo Specify:American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethleham Steel Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Noah Jackson Rosella Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1015 Stamford Rd, Balt., MD 21229 Lillian Jackson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/15/08 Owings Mills, MD Garrison Forest VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Lic risee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days SIZOSIS disease or condition resulting in death) Due to (or as a consequence of) several month monera Due to (or as a consequence of): yes, outcome of pregnancy 23d Date of delivery Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

the burial-transi

cate has been signed by the attending physician page 2 should be detached for use as the burial

and

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dire

Division of Vital Records, P.O. Box 68760,

Examiner

Be

Medical Certification: To

permit. Pages 1
Department of I
Important: If ite
any injury or ot
once.

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Be Completed

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the the licel Examination and an other traumatic event, the the licel Examination and an other traumatic event, the the licel Examination and an other traumatic event, the the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and an other traumatic event, the licel Examination and the licel Examin

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or items.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any leading to finite dialocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Completed by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 ∐Yes 2 🖳 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 🗓 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier. ego (MI)

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number

#44 Baltimor Md 21227

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

RHJA 31. Date filed (Month, Day, Year) SEP 1 0 2008

32 Registrar's Signature

Hollinsterry

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8

| | | • | State Registrar | | Cer | tificate of D | Death | Re | g. No. | | | | | |
|----------------------------|---|----------------|---|--|----------------------|---|----------------------------|---|-----------------------------|--|--|--|--|--|
| П | Discolation | ÷ | 1. Decedent's Name (First, Middle, Last) | | | | | Date of Death Month | Day Year | 3. Time of Death | | | | |
| | Physicia /Medic | | Jong K. K | Lm | | | | SEPTER | ABENS ZO | 08 9:05AM | | | | |
| | Examin | | 4a. Facility Name (If not institution, give s | treet and number) | | 4b. City, Town, or | | | 4c. County of Dea | | | | | |
| Jak | | | Seasons Hospice | | | | dallstown If Under 24 Hrs. | | | imore | | | | |
| | Funeral | | 5. Social Security Number 6. Sex | M OFFE | birthday) L Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Date of Birth (Month, Day, Sept. 28, | Year) 1932 Sou | rthplace (State or Foreign ountry) th Korea | | | | |
| | Director | | 220-80-7878 Usual Residence of Decedent | 75 75 | 1.0. | | | Bept. 20, | , 1752 300 | th Korea | | | | |
| | ow in | | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim | | | | | | | | | | | |
| | Mary Ff sh | to | MD Baltimo | ore Ow | ings | Mills | | | | 1 □Yes 2¶ No | | | | |
| | n the | Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | og. Citizen of What C | ountry? | | | | |
| | th wit | | 67 S. Tollgate Ro | oad | | 211 | 17 | | USA | | | | | |
| | ems | Funeral | | 2. Was Decedent Ever in U.S. Armed Forces? | 13. W | as Decedent of Hi Yes, specify Cuba | spanic Origin? (Sp | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | | | | | |
| 20 | or It | | 1 Never Married 2 Married | 1 ☐Yes 25 No If Yes, Give | | □Yes 2【XNo | Specify: | | Specify: | | | | | |
| Maryland 21215-0036 | filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ant, the Medical Exempler court be notified at | d by | 3 Widowed 4 Divorced | Year or Dates: | So Doord | ent's Usual Occupa | ation | | 16b. Kind of Business | Asian | | | | |
| <u>-</u> | "nat | Completed | 15. Decedent's Educ (Specify only highest grade | completed) | (Give k | ind of work done d O NOT use retired | lurina most of work | | 100, Killa of Busilless | 5/Hidustry | | | | |
| 2 | withii iene. than | mc | Elementary/Secondary (0-12) | College (1-4or 5+) | | bly line | | | Manufactu | ring | | | | |
| D D | be filed valued by the hygin of other event, I | Be C | 17. Father's Name (First, Middle, Last) | | | | | e (First, Middle, N | | | | | | |
| an | | To B | Park Tong | | | Kim Pon | | | a | | | | | |
| ar V | ss 1 and 2 should b of Health and Ment item 27 is markec r other traumatic e | - | 19a. Informant's Name/Relationship (Ty) | pe. Print) 1 | 9b. Mailin | g Address (Street a | | | City or Town, State, | Zip Code) | | | | |
| | nd 2 alth a 27 is | | Myung K. Kim | Husband | 67 S. | Tollgat | e Road, | Owings Mi | ills, MD 2 | 1117 | | | | |
| ē. | item | | 20a. Method of Disposition | 20b. Place | e of Dispos | ition (Name of atory or other place | e) | Date 2 | 20c. Location - City o | r Town, State | | | | |
| Ë | Pages nent of int: If its iry or o | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | | Mem. Ga | i | /12/08 | Finksburg | , MD | | | | |
| altimore, | permit. Pages Department of I Important: If ite any Injury or o | | 21. Signature of Funeral Service License | - | | Name and Addres | | | 4 Reisters | | | | | |
| m | 88 = 88 | | 1 IHYBE | 1 | F | line Fun | eral Home | e Reist | terstown, | MD 21136 | | | | |
| | | | 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or | cations that caused the death. I | o not ente | er the mode of dyin | g, such as cardiac | or respiratory arre | est, | Approximate Interval Between Onset and Death | | | | |
| - T | Physician | | Immediate Cause (Final disease or condition | ASPIRATION PNEUMONIA | | | | | | | | | | |
| | /Medical | | resulting in death) | Due to (or as a consequen | | | | | | | | | | |
| | Examiner | L | Sequentially list conditions. |). | | | | | | | | | | |
| | B(1/ # | inel | Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence of): | | | | | | | | | | |
| | and white | Examiner | that initiated events resulting in death) Last | Due to (or as a consequent | | | | | | | | | | |
| 60, | be ey | | | Due to (or as a consequent | | | | | | | | | | |
| 68760 | certificate be executed rding physician and ise as the burial-transit | Medical | | l | | | | | | | | | | |
| × | eath certific attending p for use as t | | IF FEMALE: | 3c. If yes, outcome of pregnancy | , | | | | 23d. Date of d | lelivery | | | | |
| P.O. Bo | atter for u | Physician | in the past 12 months? | 1 Live birth 2 Fetal de | ath 3∟ | Ectopic pregnancy Other (specify) | У | | Month Day Ye | | | | | |
| o. | that the dened by the detached | ıysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9 ☐ Unknown | | | | | | | | | | |
| | The law requires that the death ate has been signed by the atter page 2 should be detached for u | | | | | | | | | | | | | |
| g | quires t n signe ald be | q p | ANOXIC ENCEPHA | LOPATHY | | | | 1 □ Ye | es 2 No 3 | Probably 4 🙀 Unknown | | | | |
| 00 | w require s been sig should b | lete | | , | | | | 24a. Was a | | autopsy findings available | | | | |
| Re | The law te has age 2: | Completed by | | | | | | autops | med? death | o completion of cause of ? es 2 □ No | | | | |
| ta | ding Physician: The In. After this certificate hiteral director, page | Be C | 25. Was case referred to medical | | | | 26. Place of Dea | 1 □ Yes 2 th (Check only on | | 55 2 10 | | | | |
| > | ysici is cer direc | To B | examiner? 1 ☐ Yes 2 M No | lospital: 1 ☐ Inpatient 2 ☐ ER | /Outpatien | t 3 DOA Oth | er: 4 Nursing H | ome 5 Reside | ence 6 Sother (Sp | SEYISONS Decify) INSTRICE | | | | |
| Division of Vital Records, | ng Ph ter th neral | Ë | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Year) | b. Time of Injury | 28c. Injur Work | y at | 28d. Describe ho | ow injury occurred | | | | | |
| Ö | endir ath. or: Af | atic | 2 Accident investigation | | | | Yes 2 □ No | | | | | | | |
| $\frac{8}{2}$ | r Atte | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At home building, etc. (Specify) | , farm, stre | eet, factory, office | | 28f. Location (St City or Town | | Rural Route Number, | | | | |
| | ital o irs aft ral Di | Š | | | | | | | | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it | Medical | (Check only 2 Medical Exami | sician: To the best of my knowle ner: On the basis of examination | | | | | | | | | | |
| | the hin 2 the l | Ned | one) | and manner stated. | | 29c. Licens | e number | | 29d. Date signed (Mo | onth Day Year) | | | | |
| | 5 <u>8.</u> ≤ | | 29b. Signature and title of certifier | 1.44 | | 5931 | | - | | | | | | |
| • | . 7 | | | | 2-) /T | | , , - 1 | • | Septembo | 8000 | | | | |
| | 10 | | 30. Name and address of person who co | | | STREET | NHITT | ENSTON | MD | | | | | |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 32 Registrar's Signature | | <u> </u> | 1000(31 | | | | | | | |
| | Regist | | CED 1 0 200 | | A | وفيور | | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

| _ | | | For State Registrar | State of Ma | arylan | | artment of F rtificate of | | | giene Reg. No 2 | 08 | 28968 | | |
|---|--|------------------------|--|--|------------------|--|---|---|--|---|--|--|--|--|
| | Physici /Medic | | Decedent's Name (First, Middle, Le MARCIA | est) | | | KRA | MER | 2. Date of Dea | | 2008 | 3. Time of Death $\mathcal{A}: \mathcal{OSP}^{M}$ | | |
| | Examin | | 4a. Facility Name (If not institution, gi | r | | | BALTIMOR | | | | y of Death | • | | |
| | Funeral Director | | 219-34-2076 | Sex 7. Age 1 □ M 2 💢 F | 70 | last birthday) Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Date of Birt (Month, Dat 06/04/ | 1938 | 9. Birthp Cour | place (State or Foreign ntry) CA | | |
| | Aaryland f show ed at | or | Usual Residence of Decedent 10a. State 10b. County | MODE | 10c. City | , Town or Lo | | | | | 1 | 10d. Inside City Limits 1 ☐ Yes 2 No | | |
| | with the N a or 28a- | Direct | MD BALTI 10e. Street and Number | | | BALTII | 10f. Zip Code | 01000 | | 10g. Citizen of | | • | | |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 1500 BEDFORD RO 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedents Armed Forces? 1 Yes, Give Year or Dates: | Ever in U. No | | Was Decedent of Hif Yes, specify Cub. | 21208 dispanic Origin? (San, Mexican, Puert | pecify Yes or No to Rican, etc.) | - 14. Ra Bla Spec | USA ace - Americ ack, White, ify: W | can Indian, | | |
| Baltimore, Maryland 21215-0036 | vithin 72 ho sne. :han "natur ie Medical I | Completed by | 15. Decedent's Education (Specify only highest grade completed) Elementary,(Secondary (0-12) College (1-4or 5+) | | | (Give kind of work done during most of working life. DO NOT use retired) | | | | | | f Business/Industry | | |
| and 2 | be filed v ntal Hygie ed other t event, th | a | 17. Father's Name (First, Middle, Las | rt) | | AD AMED | SECRETA | 18. Mother's Nar | me (First, Middle, | Maiden Surna | | | | |
| Maryla | 12 should h and Mer 7 is marke traumatic | P | SAMUEL 19a. Informant's Name/Relationship ROBERT KLEIN / | | | 1 | • | | | er, City or Tow | FLÂX y or Town, State, Zip Code) | | | |
| nore, I | ages 1 and of Healt it item 2: | | 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 | Removal from State | OH | Place of Dispo | PARK HEI position (Name of mators) or other pla SEIH ISRA | (F) - | Date | 20c. Location | - City or To | | | |
| Baltin | permit. Pa Departme Important any Injury once. | | 4 ☐ Donation 5 ☐ Other (Spec | | _ Ai | 23 | FARD CONG 2. Name and Addre | i. U9/U ess of Facility S | 9/2008 OL LEVIN | SON & | URE, I BROS. | ми , INC. MD 21208 | | |
| | Physician | | 23a. Part1. Enter the disease, or coshock, or heart failure. List onl Immediate Cause (Final disease or condition | mplications that caused y one cause on each lin | I the death | | | | | | 1666 | Approximate Interval Between Onset and Death | | |
| 1 ML Y 68760, | The law requires that the death certificate be executed with the death certificate be executed in a paying a special state. It is a special state of the second of the sec | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as b. Due to (or as c. Due to (or as Due to (or as | a consequ | uence of): | | | | | | | | |
| χ <i>γα</i> .0. Box 6 | the death certifi | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Feta | l death 3 | □Ectopic pregnanc □ Other (specify) _ | у | | | ate of delive | rery Day Year | | |
| d rds, P | w requires that the de been signed by the should be detached | þ | Part II. Other significant conditions | contributing to death be | ut not res | ulting in the u | nderlying cause giv | ven in Part I. | | Did tobacco use contribute to the cause of death? I ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | | | | |
| \mathcal{N} \mathcal{U} \mathcal{L} (\mathcal{A} Vital Records, | . a □ | Completed | | | | | | | 24a. Was auto perfo 1□ Yes | | prior to co death? | opsy findings available ompletion of cause of | | |
| $\mathcal{N}_{\mathcal{L}}$ Division or Vita | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: To Be C | 25. Was case referred to medical 26. Place of Death (Check only one) | | | | | | | | | , | | |
| Oil | ospital or hours afte uneral Dir ly filled in t | | 29a. Certifier 1 ertifying F | Physician: To the best aminer: On the basis o | of my kno | wledge, deat | th occurred at the ti | ime, date and plac | City or To | cause(s) and | manner as | stated. | | |
| | To the H within 24 To the F complete | Medical | 29b. Signature and title of certifier. NSLINGPAN2 | and manner sta | ated. | | 29c. Licens | se number | | 29d. Date sign | ned (Month | | | |
| 8 | × sta | ate | 30. Name and address of person when N S Rey by NSCN 31. Date filed (Month, bay, Year) | o completed cause of d | nain- | St.) Su | Print) 200, | Reistersk | JIM MAND | > 21/30 | Ø · | | | |
| | Regist | rar | OED 1 0 200 | · · | 15 | A. | A. S. | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** EVELYN F₀X KIRSON /Medical 4a. Facility Name (If not institution, give street and number) Examiner V SINAI LIOSPITAL OF BALTIMORE > 5. Social Security Number 6. Sex **Funeral** رں 1 □ M 2 □ X F 99 220-56-0900 Director AIRSON. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code

2. Date of Death 3. Time of Death Month Year 6:12 PM September 2008 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE eITY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/11/1909 Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? 3737 CLARKS LANE 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PLAINE FOX WILLIAM MIRIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 RUNNING CEDAR TRAIL, MANAKIN SABOT, VA 23103

MARGARET WEINBERG / DAUGHTER 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature ♣f Funeral Service Licensee

20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW

Date 20c. Location - City or Town, State 09/09/2008 BALTIMORE, MD

23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| a | ST Elevation | Myciardial |
|------|----------------------------------|------------|
| | Due to (or as a consequence of): | |
| h. = | Hupertension | |
| | Due to (of as a consequence of): | |
| C. | | |
| | Due to (or as a consequence of): | |

hours years

Approximate Interval Between Onset and Death

IF FEMALE:

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

State

Registrar

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Magnes.

Physician

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

attending physician and for use as the burial-tran

signed by

has

this certificate

After 1

Il Director:

or Attending

To the Hospital within 24 hours a To the Funeral C

Maryland

Baltimore,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 9 ☐ Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

1 ☐ Yes 2 🛣 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 Natural

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital: 1 Annuatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Leena M.D

6 Could not be determined

29c. License number RES-000 29d. Date signed (Month, Day, Year) September 8,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE

JEENA SANDEED 31. Date filed (Month, Day, Year)

SEP 1 0 2008

MD



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

29b. Signature and title of contifier

TARIQ 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MALTMOUD

SEP 1 0

Registrar DHMH 17 Rev 1/2001 29c. License number

Ridge Road Westminster 21157

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22, 2008 6:40 PM AUGUST MAGGIE P. LEONARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FORT WASHINGTON HEALTH & REHAB FT WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours 1 □ M 2 🛛 F Director MARCH 17, 1908 100 256-52-0399 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f sho Director 1XYes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 USA 16704 VILLAGE DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐Yes 2 X No δ Specify: 3 Nidowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JIM PITTS MINNIE LEWIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT LEONARD, JR. / SON 16704 VILLAGE DRIVE UPPER MARLBORO, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Spring Baptist
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-30-2008 | RUTLEDGE, GA ri S 22. Name and Address of Facility ensee MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** JASEAST ATHEROSCLEROTI 2010 VALCOL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pus to for as a consequence of death certificate be executed and physician a s the burial-t Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) hed by the a ☐Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page ; certificate 1 ☐ Yes 2 🗓 No 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation after decth. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated.

within 2

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Baltimore, Maryland 21215-0036

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Division of Vital Records.

State

29b. Signature and title of certifier

SURESH VERGHESE 31. Date filed (Month, Day, Year)



ONCAL

PHYSICI AN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

53782

FT WASHINGTON, MD

29d. Date signed (Month, Day, Year)

20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, La 2. Date of Death Month 08 Veal **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Security Number **Funeral** Months Hours 1 □ M 2 🗗 3 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examinations to indiffed at once. 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 21215-0036 1 ☐Yes 2 No Specify þ Specify: African-American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) endleman-Hall-Milly Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VUTAN unce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attendion abusinan and the burial-trai Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 P No 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar

30. Name and address of pers

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

n who completed cause of death (Item 23a) (Type

540

Old Cou

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8 3:06 PM Mullinix 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Colombia 400a 1100 AItal Genes Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days Months Min 1 □ M 2 □ F 1934 MD 215-88-8844 Apr Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No MD Director Howard Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21771 16645 Frederick Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 □Yes 2√∑No Specify: white Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Mullinix Edgar E. Wilson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16845 Hardy Rd., Mt. Airy, MD 21771 R. Allen Mullinix Jr. (son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Sykesville, MD Lake View Memorial 9-13-08 4☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Haight Funeral Home & Chapel Daige slaight stenbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dea disease or condition resulting in death) nevenone Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. 25. as case referred to medical examiner? Ster 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, P.O. been signed by the should be detached Division of Vital Records, nis certificate has director, page 2 s To the Hospital or Attending Physician; After this c

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amp Injury or other traumatic event, its invidical Eventials.

Physician

/Medical

Baltimore, Maryland 21215-0036

Physician/Medical 2 Completed Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

mando

D 1 0

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea MAMO **Physician** 1740 PM EHETU SEPTEMBER 8 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) Tan. 27, 1942 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Yrs Ethiopia None 66 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Virginia Fairfax Alexandria 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code with 22310 6906 Victoria Dr., Ethiopia Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ XNo within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene 3 Entrepreneur Self-employed filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Pages 1 and 2 should be Tsige Mamo Eshete Demsse 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 6906 Victoria Dr.,#L, Alexandria, Virginia 22310 Eshetu/Daughter Kidist 20b. Place of Disposition (Name of cermetery, crematory or other place)

St. Peter & St. Paulos 9/17/2008 Addis Ababa, Ethiopia

22. Name and Address of Facility

22. Name and Address of Facility

22. Name and Address of Facility 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 171 W. Maple Ave. M00968 Money & King Funeral Home, Inc. Vienna, Va. 22180 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METATIATIC CHOLANGIO CARLINOMA disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-transit (E resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year page 2 should be detached for Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 1 🗌 Yes 2 XNo 2 🗌 No 1 Tes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 No 3 🗆 DOA 2 ER/Outpatient မ To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Attending М 1 🗌 Yes 2 🗌 No death. 2 Accident within 24 hours after deatl To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RE(_ 000 SEPTEMBER, 8, 200X O. NASIR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar OMER MASIR

31. Date filed (Month, Day, Year) SEP 1 0 2008

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:42M James Michael Monroe, Sr. ntember 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/01/1941 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Maryland Director 220-36-8647 67 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, I'm in added Evanting the notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Arbutus Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 1120 Elm Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Programmer CSX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl H. Monroe Stella R. Kamzura ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 Elm Rd. Arbutus, Maryland 21227 Mary M. Monroe (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 09/15/2008 Towson, Maryland 21. Signal ue of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Dundalk, Maryland 21222 Inc. 7922 Wise Ave. 23a, Part+. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ulmonar disease or condition resulting in death) /Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-1 Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □ No. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s autopsy performe certificate 2 **V** No 2 🗹 No 1 ∐Yes 1 ☐ Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) rthisr 1 Tes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 🗌 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 995

State

Registrar

31. Date filed (Month, Day,

0

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7:54 P M Argyle T. Martin, Sr. September 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City N/A Johns Hopkins Bayview Medical Ctr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31,1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) untry) st Virginia Days Hours **X**XM 2□ F 80 West 233-38-0842 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Dundalk Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21222 United States 7966 St. Monica Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. ²□No Korea Affiled Forces: 1 Gyes 2 No Korea If Yes, Give Year or Dates: Veitnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Army G.E.D. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vera Olive Whitlock Willis Homer Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 7966 St. Monica Drive Dundalk, MD Mrs. Toynette M. Martin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

Physician /Medical **Examiner**

> burial-transi and

nding physician a use as the burial-

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certificate has been signed by the atte rector, page 2 should be detached for i

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after death.

I Director: After d in by the funers

To the Hospital or within 24 hours at To the Funeral D

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Certification: To

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Division of Vital Records,

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Nadical Examinating Item Interest De Intilliad at once.

Baltimore, Maryland 21215-0036

Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from

4 ☐ Donation 15 ☐ Other (Specify) 21. Signature A Funeral Service Li

| Budd Ruck Tunezar neme | 1C. .222 |
|--|--|
| 71 W/1-4 / // / W/A/// | .222 |
| 7922 Wise Ave. Dundalk, Maryland 21 | |
| 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Tryanchion my resulting in death) | nutco |
| Due to (or as a consequence | |
| Hypertension | zas |
| Se juentially list conditions, D. Due to the as a consequence of): cause. Enter Underlying | |
| Cause (Disease or injury that initiated events c. | |
| resulting in death) Last Due to (or as a consequence of): | |
| d | |

rownsville V.A. Cem. 9/8/2008

Physician/Medical IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

9 Unknown

☐Yes 2☐No

| 4 Pregnant at time of death | 5 Other (specify) |
|--|--------------------------------|
| ributing to death but not resulting in t | he underlying cause given in I |

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death?

Crownsville, MD

sidemia, well-controlled or

23c If yes, outcome of pregnancy

| 1 ∐ Yes ∠ | NINO 3 | Probably | 4 U Olikilowi |
|---|--------|---|---|
| 24a. Was an autopsy performed? 1 □Yes 2≥No | death | autopsy fi o completi ? es 2 1 | ndings available ion of cause of No |

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural
2 Accident

5 ☐ Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

3 Suicide

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4924 Campbell Blud. Suite 200/Balto MD egistrar's Signature

State Registrar

| 08-0681 | 3 |
|----------|--------|
| Jennifer | Miklic |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ennifer Miklic | | | Maryland / Dep | artme | | | | | 2 | 2008 | 2897 |
|--|----------------|--|--|-------------------|---|----------------|--------------------------|-----------------------------|--------------------------|------------------------------|--|
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Last) | | lilica | - Dealli | | 2. D. | Reg ate of Death | . No. | 13. | Time of Death |
| ledical Exami | | Jennifer M. Mik | | | | | Se | | 5, 2008 | 'ear | 1845 hrs |
| | | 4a. Facility Name (if not institution, give str 618 Island Creek Road | eet and number) | | 4b. City, Town, of Annapolis | or Location of | Death | | | ty of Death Arundel | |
| Funeral Director | | 5. Social Security Number 6. Sex | 7. Age (In yrs. | last birtho | day) If Under 1 Ye Months Da | | Min | | ` | Count | olace (State or Foreign Ohio |
| Director | | 275-90-3959 1 M | 2X F | 24 | Yrs. | , | F | <u>ebrua</u> | ary ⁶ , | 1984 | Onio |
| any | | 10a. State 10b. County | 10c. City | , Town or | Location | | | - | | | 0d. Inside City Limits |
| daryland 28a-f show 1 at once. | tor | Maryland Anne Ar | undel Ann | apo | | | | | | | Yes 2X No |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once | Director | 10e. Street and Number 618 Island Cree | k Road | | 10f. Zip Code 21401 | | | | S.A. | What Country | f? |
| with t ms 23a be not | eral | | 2. Was Decedent Ever in U Armed Forces? | J.S. | 13. Was Decedent of H If Yes, specify Cuba | | | Yes or No- | 14. Ra | ice - America | n Indian, Black, |
| er death , or ite | Fun | 1 Never Married 2 Married 1 3 Widowed 4 Divorced | Yes 2X No | | | | ruerto Nica | 11, 6(0.) | | y: Whit | 0 |
| urs afte | d by | 3 Widowed 4 Divorced of or 15. Decedent's Education (Specify only h | Dates: | | 1 Yes 2X N | ation (Give ki | | done | | Business/Ind | |
| 6 172 ho an "na cal Ex | leted | Elementary/Secondary (0-12) | College (1-4 or 5+) | | iring most of working lif | fe. DO NOT u | use retired) | | | | |
| 5-0036 led within 7 Hygiene. other than | omplete | 10 17. Father's Name (First, Middle, Last) | | La | oorer | 18 Mother's | Name (Firs | t Middle M | Food | | aration_ |
| 215 be filed ntal Hy rked of | Be C | Steven Miklic | | | | | , | posit | | | |
| 5, MD 21215-0036 and 2 should be filed within 72 hou teath and Mental Hygiene. item 27 is marked other than "nat traumatic event, the Medical Exa | ٥ | 19a. Informant's Name/Relationship (Type | , Print) | 4. | Mailing Address (Stre | eet and Numb | per or Rural | Route Numb | er, City or T | | |
| e, MD 1 and 2 sho Health and item 27 is | | Diane Reese 20a. Method of Disposition | | Place of | 000Calabo Disposition (Name of c | one R | Road, | Doyle e T | 20c. Locatio | n , Ohi on - City or To | O 44230 Own, State |
| more Pages 1 nent of H ant: If i | | 1 Burial 2 X Cremation 3 | Removal from State Ba | cremator VVie | y or other place) ew Cremat | orv | 9-10 | -08 | Ral+4 | imoro | ,Maryland |
| Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum | | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee | | _ | 22. Name and Addres | | | | | | hapel, P.A |
| | | michael I margine | lf- | 5 | 6009 Har | iord | Road | ,Ba⊥t | imore | e,Mar | y1and2121 |
| Physician /Medical | | 23a. Part I. Enter the disease, or complica failure. List only one cause on each I | ine. | | | g, such as ca | rdiac or resp | oratory arres | st, snock, or | neart | Approximate Interval Between Onset and Death |
| xaminer | | | to (or as a consequence | | ation | | | | | _ | |
| | Į. | Sequentially list conditions, if any, leading to immediate b | to (or as a consequence | of): | | | | | | _ | |
| | Examiner | (Disease or injury that initiated C. | | | | | | | | 63 | |
| executed an and all - transit | | d. | to (or as a consequence | • | | | | | | | |
| g e e e e e e e e e e e e e e e e e e e | dical | X UNPENDED A | MENDED 23a,27 | ,28a- | -f, perME, | g884 | 10/2/ | 08 TT | | | |
| tox 68760 eath certificate be attending physi | cian/Me | 23b. Was decedent pregnant in the | 3c. If yes, outcome of pre | gnancy | Fetal death 3 | Ectopic | pregnancy | | 23d. Date Month | of delivery | y Year |
| Box 6 e death cer the attendii ed for use a | · | past 12 months? | Pregnant at time of d | eath 5 | Other (Specify) | | | | 1 | | |
| that the de ned by the detached t | Phy | Part II. Other significant conditions col | | resulting | in the underlying cause | given in Par | tı. | 23e. Did tob | acco use co | ntribute to the | e cause of death? |
| ires that to signed by 1 be detac | d by | | | | | | [| 1 Yes | 2 No | 3 Probal | oly 4 🗸 Unknown |
| of Vital Records, ng Physician: The law require the control of t | ompleted | | | | | | | 24a. Was a | у | prior to cor | psy findings available npletion of cause of |
| tal Rec | Com | | | | | | | perform 1 Y Yes 2 | | death? 1 ✔ Yes | 2 No |
| 'ital sician: is certif | å | 25. Was case referred to medical examiner? | pital: 1 Inpatient 2 | ER/Out | 26.Place | Other | Check only Nursing Ho | | Residence (| 6 Other: S | Scene |
| r of V ing Phys After thii funeral di | 7: To | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | _ | | jury at Work? | | | ow injury occ | | |
| tendii death. | atio | 1 Natural 5 Pending 2 Accident Investigation | Fnd 9/5/08 | unk | 1 | Yes 2 X | | | | | |
| Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate Paneral Direc or: After this certificate has been signed by the attending physicial pile in by the funeral director, page 2 should be detached for use as the b | Certification: | 3 Suicide 6 X Could not be | 28e. Place of Injury - At h | nome, farr OME | n, street, factory, office | building, etc | 28f. | Location (Story Town, Story | reet and Nur ate) 618 | mber of Rura Island VD | Route Number, City, d Creek Rd |
| Division To the Hospitat or A tend within 24 hours after ceath To the Funeral Direc or: completely filler in by the l | | 29a. Certifier 1 Certifying Physician: | To the best of my knowled | | | | ce, and due | to the cause | (s) and man | ner as stated | |
| To the vithin 2 To the complet | Medical | one) 2 Medical Examiner: On an 29b. Signature and title of certifier | the basis of examination a distribution and manner stated. | and/or inv | | nse number | urred at the | time, date a | | igned (Monti | |
| | - | // a.l. | and | | | S.M.E. | | | | per 6, 200 | |
| X | İ | 30. Name and a dress of person who com | ` ` ` | , | | 5-7- | | | | | |
| P | لب | Laron Locke MD. Assistan 31. Date filed (Month, Day Year) | t Medical Examiner 32. Registrar's Signal | - 1 | Penn Street, Balt | imore, MI | 21201 | | | | |
| <u> </u> | -17. | o i. Date lilea (WOTH). Day, Year) | TOL. NOUSURE S CHAPTER | WILL ATTE | * A.F. F | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** entember 8 20 oore /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltmore Hispital (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. Date of Birth Month Day, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 耳 F Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Mes 2 □ No Director timore Apt. 1109 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Hvenue Ivania Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ¥Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chaineer 's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 18. Moth Be 1 and 2 should be f Health and Mental I 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) nformant's Name/Relationship (Type. Print) Teakwood Dr. Apt. Al. permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other tra. tikesville, and DON Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Sign tue of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 0 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Vear 5 Other (specify) P.O. ned by the a 9 Unknown 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 1 ☐Yes 2 ☐No 2 No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type,) Print) Mabbie Mudha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | • | For State Registrar | State of Maryla | | ertificate of | | | eg. No. 2008 | 3 28979 | |
|---|---|-------------------------------------|--|--|---------------------|--|--|---|--|---|--|
| | Dharisis | - 2 | 1. Decedent's Name (First, Middle, La | st) | | | 2 | 2. Date of Deat Month | th Day Year | 3. Time of Death | |
| | Physicia /Medic | | John Patrick Mu | | | | | ugust | 20 200 | 8 14:18 M | |
| 4 | Examin | er | 4a. Facility Name (If not institution, gir | 0 | | . 11 | r Location of Death | J | 4c. County of Dea | ath | |
| | | | 5. Social Security Number 6.5 | Sex 7. Age (In yrs | inere | Balfima If Under 1 Year | If Under 24 High | B. Date of Birth |) 9. Bi | rthplace (State or Foreign | |
| | Funeral Director | | 217-58-3727 Usual Residence of Decedent | 1 ₹ M 2 t F 57 | | Months Days | Hours Min. | B. Date of Birth (Month, Day, Iar 18, | 1951 Mar | yland | |
| | land ow | # | 10a. State 10b. County | 10c. C | City, Town or | Location | | | | 10d. Inside City Limits | |
| | a-f sh | cto | MD Washing | ton | Hage | rstown | | | | 1 □ Yes 2√ No | |
| | n with the | al Dire | 10e. Street and Number 28 Hump Road | | | 10f. Zip Code | 21740 | 1 | 0g. Citizen of What C | Country? | |
| 17 R. C.K. 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If it Medical Examinat must be notified at once. | To Be Completed by Funeral Director | 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates: | U.S. 1 | 3. Was Decedent of HIf Yes, specify Cub. 1 □Yes 2☑No | lispanic Origin? (Spec an, Mexican, Puerto Ri Specify: | | | white | |
| ck 5-0 | 72 hc | etec | 15. Decedent's E (Specify only highest gr | ducation ade completed) | 16a. De (Gi | cedent's Usual Occup ive kind of work done | oation during most of working d) | , | 16b. Kind of Business | s/Industry | |
| PATRICK 1d 21215- | within sne. | du | Elementary/Secondary (0-12) | College (1-4or 5+) | 1 | e. DO NOT use retire .aborer | d) - | | concret | ·e | |
| AT CO CO CO CO CO CO CO CO CO CO CO CO CO | | | 17. Father's Name (First, Middle, Las | | | aborer | 18. Mother's Name (| First, Middle, I | | | |
| J | d be ental ked o | o B | John James Murph | • | | | Betty N | | | | |
| Journ P. Maryland | nd 2 shou lith and M 27 is mar r traumat | | 19a. Informant's Name/Relationship (Type. Print) Ruth kaufman/sister 19b. Mailing Address (Street and Number or Rural Route Number, Ci 128 Clarkson Avenue Hagerstown, | | | | | | | Zip Code) 740 | |
| Muzphy, Baltimore, | ages 1 arent of Heart II item | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | Removal from State | Place of Dis | sposition (Name of rematory or other place | ce) Da | te | 20c. Location - City o | r Town, State | |
| Mบ2PHY Baltimor | permit. F Departm Importar any injur | | 4 Donation 5 Mother (Specify) in state 21. Signature Euneral Service License 1 irector Statement after any after a | | | | | | | | |
| 7 | Physician /Medical Examiner | Examiner | 23a. Partil. Enter the disease, or conshook, or heart failure. List only Immediate Lus. (Final disease or contion resulting in death) Source trails for our litture, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | equence of): | rdial influence of dyi | | respiratory arr | rest, | Approximate Interval Between Onset and Death 10 day | |
| J. Box 68760, | rtificate be ng physicia as the bur | Physician/Medical Ex | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23d. Date of d Month | elivery Day Year | | | | | | |
| P.0 | hat th | Phy | Part II. Other significant conditions | contributing to death but not re | esulting in the | underlying cause giv | ven in Part I | 23e. Did to | bacco use contribute | to the cause of death? | |
| ds, | uires t signe d be | d by | DIABETES | · · · · · · · · · · · · · · · · | 3 | - , 5 5 | | 1 ▼ Y | es 2 □ No 3 □ i | Probably 4 Unknown | |
| al Recor | : The law req cate has beer page 2 shou | Completed | | | | | | 24a. Was a autops perfor 1 □ Yes | med?// death? | autopsy findings available o completion of cause of es 2 1100 | |
| Vita | ician certifi ector | Be | 25. Was case referred to medical examiner? | Hospital: | | Ott | 26. Place of Death | | | | |
| of | Phys | <u>۱.</u> | 1 ☐ Yes 2 17/No 27. Manher of Death | 1 Ma Inpatient 2 | | tient 3 🔲 DOA | 4 ☐ Nursing Hom | | ence 6 Other (Sp ow injury occurred | pecify) | |
| Division of Vital Records, | To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendition completely filled in by the funeral director, page 2 should be detached for use | Certification: To | 1 Natural 5 Pending investigatic 3 Suicide 4 Homicide 5 Pending determined | De See Place of Injury At | | y Wor M 1□ |]Yes 2□No | | treet and Number or i | Rural Route Number, | |
| | ie Hospit: 24 hours ie Funera | Medical C | | hysician: To the best of my ki miner: On the basis of exami and manner stated. | | | | | | | |
| | To the To the comp | Me | 29b. Signature and title of certifier | | | 29c. Licens | | 2 | 29d. Date signed (Moi | nth, Day, Year) | |
| | | | romestrau | , M.D | · | KES | -000 | | August 2 | 20, 2008 | |
| | | | 30. Name and address of person who | | em 23a) (Typ | e, Print) | -0 . 0 | n i | 1000 | * | |
| | - Sta | e. | 31. Date filed (Month, Day, Year) | ANOM M. D. 32. Registrar's Sign | nature | nai Mos | pirel of | 5a11 | fimore. | | |
| | Registra | | SEP 1 0 200 | See 15 | for | di | / | | | | |

DHMH 17 Rev 1/2001

08-06788 Damion McCray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 28980

| Official | | or State | Certifica | ate of Death | | | Reg. No. | | 1 |
|--|----------------|--|---|---|---------------------|-----------------------------------|---------------------------------------|-----------------------|---|
| Physician/ | 1. | Decedent's Name (First, Middle,Las | nion McCray | | | | nber 5, 2008 | 'ear | 3. Time of Death 0005 hrs |
| | 4a | Facility Name (if not institution, given 7844 Woodside Terrace | re street and number) | 4b. City, Town, Glen Burn | | | Anne | ty of Deat Arundel | |
| Funeral Director | 5. | Social Security Number 6. S 15-94-4685 1 | ex 7. Age (In yrs. last birth | T Mantha D | | fin. Jan | of Birth (MM/DD/YY | Forei | ountry) May laid |
| w any | _ | ual Residence of Decedent a. State 10b. County | 10c. City, Town | or Location | Battine | re | | | 10d. Inside City Limits 1 Yes 2 No |
| with the Maryland ns 23a or 28a-f show be notified at once. | 10 | le. Street and Number | till Ave. | 10f. Zip Code | 21217 | | 10g. Citizen of | What Co | untry? |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she market coult, the Medical Examiner must be notified at once | | Marited Status Never Married 2 Marrie | 1 Yes 2 No | 13. Was Decedent of If Yes, specify Cul | oan, Mexican, Pue | Specify Yes of erto Rican, etc | | hite, etc. | Pock |
| 72 hours after n "natural", al Examiner | ⋧┞ | Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12) | If Yes, Give Year or Dates: Only highest grade completed) College (1-4 or 5+) | Decedent's Usual Occuduring most of working | pation (Give kind | retirea) | 16b. Kind o | f Business | s/Industry |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours afforent of Health and Mental Hygiene. I titem 27 is marked other than "natural onther transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic event, the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other transmatic events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Examinate or other events and the Medical Ex | naiaidiuon ag | 7. Father's Name (First, Middle, Lat | st) | | 18.Mother's Na | ame (First, Mic | 1 | | |
| ore, MD 21215-0U3 set 1 and 2 should-be filed with of Health and Mental Hygiene If item 27 is marked other it her traumatic event, the Mo | 0 1 | 9a. Informant's Name/Relationship Gail McCray | -grandonother | 2019 DI | und Hil | or Rural Rout | - LARTHON | Bu | ate, Zip Code) 2/2/7 Ho, MD, or Town, State |
| Baltimore, MD sernit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati | | 0a. Method of Disposition Burial 2 Cremation Donation 5 Other Spec | Removal from State Met | of Disposition (Name of atory or other place) 22. Name and Ado | ory G | 7-12-0 | 8 Cato | nsvi | Ik, Marylan |
| Balt permit Departi Import injury | 1 | 1. Signature of yur ral Service L | ns e | 3572 Fren | deric 1 | R. Ba | Himo ory arrest, shook, o | Mar or heart | Approximate Interval |
| Physician fedical aminer | | failure. List only one cause on mmediate Cause (Final disease or condition resulting in death) | each line. a. gunshot wound of head Due to (or as a consequence of): | | | | | | Death |
| | | Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause | b. Due to (or as a consequence of): | | | | | | |
| uted od | Exam | (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): d. | | | | | | |
| ate be executed by sician and reburial - trans | Medical | UNPENDED | AMENDED | | | | Local D | -t- of doli | |
| Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit | | F FEMALE: 3b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnand 1 Live birth 4 Pregnant at time of death | 2 Fetal death 5 Other (Specify | 3 Ectopic p | regnancy | | ate of deli nth | Day Year |
| Division of Vital Records, P.O. Box 687 the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death. After this certificate has been signed by the attending the Funeral Director: After this certificate has been signed by the attending ripletely filled in by the funeral director, page 2 should be detached for use as it | | 1 Yes 2 No 9 Unkn | ns contributing to death but not result | ting in the underlying ca | use given in Part | | | | e to the cause of death? Probably 4 Unknown |
| of Vital Records, F ng Physician: The law requires ther this certificate has been sign ther director, page 2 should be | Completed | | | | | _ | a. Was an autopsy performed? Yes 2 No | prior deat | e autopsy findings available to completion of cause of the Yes 2 No |
| Vital Reco | 녌 | The state of the s | | 26 | Place of Death (C | | | | |
| ician: | å | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 ER | VOutpatient 3 DO | Other 1 | Nursing Home | 5 Residence | 6 🗸 | Other: Scene |
| n of Virding Physic | on: To | 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pendi | 28a. Date of Injury 28 (Month, Day, Year) 23 | | c. Injury at Work? | _{√o} Subje | escribe how injury ct shot | | |
| Division tal or Attending all Directors Alled in by the full led in by | Certification: | 3 Suicide 6 Could determ | (vicing) | Apt | | 7844 V | Town, State) Voodside Terrad | ce, Glen | |
| Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / | Medical Ce | 29a. Certifier 1 Certifying Phyone) 2 Medical Exam | ysician: To the best of my knowledge, niner:On the basis of examination and/ and manner stated. | or investigation, in my o | opinion, death occu | e, and due to urred at the tin | ne, date and place | , and dec | to the cause(s) (Month, Day, Year) |
| To witi | Me | 29b. Signature and title of certifier | hird The me | 0 | O.C.M.E. | OCME | | ember 5 | |
| j | | 30. Name and address of person Theodore M. King, Jr., | | aminer 111 Per | nn Street, Balt | timore, MD | 21201 | | |
| S | tate trar | AFD 4 1 201 | 32. Registrar's Signature | back | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year September 6:30 PM CARRIE S. NORMAN 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES Pear If Under 24 Hrs. 8. Date of Birth
May 10, 14999 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Days Director 062.07.4999 99 SC Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits the notified at Director <u>Prince</u> George's Mitchellville 1 □Yes 2 □No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 3911 Lottsford Vista Rd USA event, the Medical Exercitive coust Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married P 1 □Yes XX No þ 3 □xwidowed 4 □ Divorced Specify: 'natural", BI ACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the angles. HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be REV. JOHN T. SMITH ဥ MOLLY SIMPSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. JOHN SIMS 8110 STEVE DR. FORESTVILLE, MD 20747 Method of Disposition
↑ Burial 2 □ Cremation 3 ★ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sept 13, 2008 4 Donation 5 Other (Specify) WILTWYCK CEMETERY KINCSTON, NY 21. Sign (L/a) Funeral S, rvice L 22 Name and Address of Facility P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW GLEN BURNIE MD 21061 CHECORY FINA M01148 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C., se (Final disease or condition resulting in deal) MCEPHALOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner NSIDIGNETITEGY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or, the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit AMEMIA and Due to (or as a consequence of): the attending physician Physician/Medical ころろいしのりますけて IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Juliknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

VORMAN

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 10

.eez

DHMH 17 Rev 1/2001

MS

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

ARIOSUM

29c. License number

767410

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EELE Year HROLY N 1:05AM 08 /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death ear 1 Under 24 Hrs. 8. Date of Birth Min. Month, Day, Bon Secours N 5. Social Security Number 6 Sex Funeral (In yrs. last birthday) Year 9. Birthplace (State or Foreign Marya d 212-48-1 □ M 2 □ F Months Days Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Marylana Completed by Funeral Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ? 53 Lucia USF 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Newer Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 ☑ No 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) Otoria Perkins 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Department of H Important: If ite any injury or ot once. Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Ap roximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and The law requires that the death certificate be exec burial-t Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical as the the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Pregnant at time of death Month Dav Year 1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy this certificate 1 ☐ Yes 2 -No 2 10 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WICLAN

State Registrar BALTIMORE

BALTIMORE MD 81223

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDHU, M.D

0 2008

31. Date filed (Month, Day, Year)

940

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. Z 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Sestum Dec James 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner 500 70 O Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) If Under If Und 5. Social Security Number 216=54-22 7. Age (In yrs. last birthday) 6. Sex **Funeral** 18M 2□ F Months Days Hours Min. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Ever it are must be redified at 1 PYes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ງວ_{າດເງ}ິກປາປາດປາວທ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: K C.C If Yes Give Completed by 3 Widowed 4 Divorced Year or Dates of Business/Industr 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maintenance permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If tilem 27 Is marked any Injury or other the 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be homas ဂ္ဂ or Rural Royte Number, 19b. Mailing Address (Street and Number -daughter 2703 Charlita Nichardsen 20b. Place of Disposition (Name of centery, crematory or other) Date or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nrovimate nterval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy for 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 ☐ Probably 4 ☐ Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sh autopsy performed? Yes 2 No 2 No 1 ☐Yes 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 1 Inpatient Certification: To this 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a

To the Funeral C

completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of serson ოჩი completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 1 0 2008

204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20081 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** tambur 2008 /Medical 4a. Facility Name (If not institution, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. 1 Year Birthplace (State or Foreign Country) Social Security Number last birthday **Funeral** 18 1963 Months Days Hours Min. 1 M 2 F Critcher Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, Ite Nedical Exaction must be notified at 1 Nes 2 No Director Himore mi 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21233 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Mo Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 ■ N6 Specify: Specify: Black 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Important: If Item 27 is marked other than any Injury or other transmission Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Baltimore, lather MD 21239 Burnwood 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility gnature of Funeral Service License Howell Balto. M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final **Physician** 1-mmunode Ficiency Due to (or as a consequence of): disease or condition resulting in deeth) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Due to (or as a consequence of): and burial-tran Box 68760, attending physician Physician/Medical the as for use a IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 ☐ Pregnant et time of death 5 Other (specify) P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, β 3 Probably 4 Unknown 1 🗌 Yes 2 🔲 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy After this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident the nosperation 24 hours after death.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) 82. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept 7, 2008 Year Physician 2:31 A Richard A. Soyka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil County Hospital Ceci1 E1kton If Under 1 Year 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Hours Min 1 X X 2 F 190-38-3879 Nov 19, 1946 PA 61 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show 1 Yes 2 No Director PA Glenolden Delaware 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1036 Oakwood Dr 19036 USA Funeral 14. Race - American Indian, items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 XXMarried Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🕅 📉 o Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fitter/Welder General Electric 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenonce. George Soyka Blanche Donnelly ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Soyka Wife 1036 Oakwood Dr, Glenolden, PA 19036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 NBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SS Pèter & Paul Cem Sept 12, 2008 Springfield, PA 21. Signature of Funeral Service L 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 Fink 426 Crain Hwy S., Glen Burnie, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Physician /Medical Due to (or as e consequence of): Examiner SCV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the aftending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) nours after death.

neral Director; After the filled in by the funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation M 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 106 Bow Street E1 La Rocco 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 SEP 1 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Phillip E. Sargent, Sr. September 9 2008 3:15 Α /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 9121 Gross Avenue Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 5, 1931 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral Days Hours 1 □ XM 2 □ F 76 Yrs. MD Director 216-28-4211 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "McCall Event har aust be notified at 1 ☐ Yes 2 No Director MD Howard Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20723 USA 9121 Gross Avenue Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

12 Yes 2 No 1950 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1xxYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify Specify: white 2 3 Widowed 4 Divorced 54 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Corrections 10 Correctional Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Jones Vernon Cornell Sargent, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Blanche Alberta Sarent/wife 9121 Gross Ave., Laurel, MD 20723 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If iter
any Injury or oth 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Emmanuel UMC Cem. Scaggsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Ave., Laurel, MD 20707 /M01053 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Pricumonia /Medical Due to (or as a consequence of): Examiner Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transi Exami and Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical nding r as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform **2**¥**Z**No 2**X**No Division of Vital 1 □Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? spital or Attending Phours after death.
neral Director: After or y filled in by the funera 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in KXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 9, 2008 H59597 D.O. naerma isx, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8871 Gorman Road, Laurel, MD 20723 MD, Susan Madonna, Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 SEP 10 Registrar

DHMH 17 Rev 1/2001

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AMEND ITEM#20b perFH, G883, 9/18/08, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 28987 Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Zith 2008 Month **Physician** 4:26P M August DIMMS VIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number). 4b. City, Town, or Location of Death Examiner of Mary Center land Medical Baltimore NA uivers.t 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F Months Director 212-66-6812 50 OCT 4, 1957 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Experient must be notified at 1 X Yes 2 No Director MD PRINCE GEORGE'S LANDOVER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 USA 6503 LANDOVER ROAD #201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔯 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Completed by Specify: 3 Widowed 4 Divorced BLACK. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. PRIVATE SECURITY GUARD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental H is marked VIVIAN E. JOHNSON JAMES EMMANUEL SIMMS ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 is VIVIAN E. SIMMS / MOTHER 1077 LARGO ROAD #603 UPPER MARLBORO, MD 20774 permit. Pages 1 as Department of Her Important: If item any injury or othe QDCE. Date UNK 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-22-08 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM VETERANS CHELTENHAM, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 20746 4308 SUITLAND ROAD SUITLAND, MD DONALD R. GRAY Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, shock, or heart failure. L implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Steene End /Medical Due to (or as a considerence of) Examiner Hepatitis Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Luc to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 200 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation within 24 hours after death.

To the Funeral Director: the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be filled in by 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August, 29th 2008 19000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St, Baltimore, MD 21201 22 8. Gregor MY

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 1 0 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13:13 PM Physician 2008 Squiers September harles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOPKINS Bayview Medical Center Baltmore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 61 11-21-1946 218-46-5691 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Dundalk Baltimore 1 ☐ Yes 2x No MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 711 Gregwood Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Sanitation Worker 7 is marked other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Louise M. Clark John G. Squires ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 711 Gregwood Court Dundalk MD 21222 permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra once. Marlene E. Squires (Wife) Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ Removal from State Hilltop Service Corp. 09-12-2008 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of FacilityDuda-Ruck Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 7922 Wise Avenue Dundalk MD 21222 Inc. lones art1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure clist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician S-eptic SHOCK 2 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) P.O. Box 68760, ≪ burial-tran Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) the 9 I Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy perform ueam? 1 □ Yes 2 ⊡ No 2 | No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R45-000 September 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Eastern trenue Baltinove, MD HCKS 4940 Hehleigh M.D. 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar 2008 0

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G884, 1073/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Queenie Smith 7:478 SEPTEMBER 7 2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Min. **Director** 213-30-0408 73 Nov. 12, MD Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Examina aust be notified at MD Director Accokeek 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18606 18606 Independence Road 20607 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: Specify: Black 3₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. Elementary/Secondary (0-12) College (1-4or 5+) 9 seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William B. Smith ပ Rose Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean R. Lann / Sister 2 Fitzharding Place; Baltimore, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 09/12/2008 Baltimore, Maryland 22. Name and Address of Facilify Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 9200 Liberty Road; Baltimore, Maryland 21133 2 a. Part littler Le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE disesse or condition sulting in death) RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yo 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) P.O. I ed by the 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been s certificate has b irector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{SOTOTE Other (Specify)} \) SEASOWS 1 Yes 2 No 1 Inpatient this Certification: To 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. September 8,2008 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 16rce DO 25 MAIN STREET REISTENSTOWN MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

| | | | Please | Type or Prin | | | | | | | | | |
|-------------|---|------------------|--|---|----------------------------------|---|-----------------------------|---|--|---|---------------------------------------|--------------------------------|------------------------------|
| | | | For State | State of Ma | aryland / | Departme <i>Certifica</i> | | | /lental Hy | gien Rea. N | 2000 | 25 | 3990 |
| | | | State Registrar 1. Decedent's Name (First, Middle, Las | it) | | Certifica | le oi i | Death | 2. Date of De | eath | | 3. Tim | e of Death A |
| | Physicia /Medic | | Franklin Sc | hulma | N | | _ | | Septe | mber | - 8 21 | | 2:58 M |
| | Examin | | 4a. Facility Name (If not institution, give | | 11,000 | | thmu | Location of Death | • | 2 | c. County of Dea | th | · h |
| | Funeral | | 5. Social Security Number 6. Social Security Number 6. Social Security Number 7. 6. Social Security Num | ex 7. Age | iltimor e (In yrs. last bi | 0 | er 1 Year | if Under 24 Hrs Hours Min. | 8. Date of Bi | rth | 9. Bird | thplace (Sta | te or Poreign |
| ji. | Director | | 0/8-18-3118 | Д М 2□ F | 84 | Yrs. | Days | riouis Willi. | 07/10 | /192 | 24 | NY | |
| | yland Jow at | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tov | vn or Location | | | | | | | e City Limits |
| | e Mar Ba-f sh tiffed | Director | MD BALTIMO | ORE | BAL | TIMORE | | | | | | | Yes 2 No |
| | with the | Dire | 10e. Street and Number 3000 STONE CLIFI | E DDIVE # | 302 | 10f. 2 | ip Code | 21209 | | 10 g . C | itizen of What Co | SA | |
| | death ms 23 | Funeral | 11. Marital Status | 12. Was Decedent I Armed Forces? | | 13. Was Dec | | ispanic Origin? (Span, Mexican, Puerl | pecify Yes or N | 0- | 14. Race - Ame Black, Whit | erican Indiar | 1, |
| 215-0036 | be filed within 72 hours after death with the Maryland to Hyglene. Hyglene. do they than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by | 1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced | 1 M Yes 2 ☐ N If Yes, Give Year or Dates: | | 1 □ Yes | 2 💢 No | Specify: | | | Specify: | WHITE | |
| - - - | n 72 h "natu edical | Completed | 15. Decedent's Ed (Specify only highest gra | de completed) | | a. Decedent's Us (Give kind of v life. DO NOT | ork done | during most of wor. | king | 16b. I | Kind of Business | Industry | |
| 212 | d withi giene. er thar | Somp | Elementary/Secondary (0-12) | College (1-4or 5 5+ | +) | ELECTRI | CAL E | NGINEER | | | COMP | UTERS | |
| 2 | should be filed nd Mental Hygi marked other matic event, <u>t</u> | Be | 17. Father's Name (First, Middle, Last) | | CCUULN | e A Ni | | 18. Mother's Nan | ne (First, Middle | e, Maide | | ENBER | c |
| Maryland | 2 should I and Men is marker aumatic | ဥ | MEYER 19a. Informant's Name/Relationship (7) | Type. Print) | SCHULM 19 | | ss (Street | LENA and Number or Ru | ral Route Numi | ber, City | | | u |
| | nd 2 alth a 27 is | | ANITA SCHULMAN | | 3 | 3000 ST0 | NE CL | .IFF DRIV | | | | | 21209 |
| altimore, | Pages 1 and the total total term int: If item iny or other | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ | Removal from State | 20b. Place of cemet | of Disposition (N | ame of rother plac | ce) | Date | | Location - City or | | 9 |
| <u>=</u> | permit. Pages Department of Important: If it any Injury or o | | 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen | | CHTZ | | | IG. 09/0 | 9/2008 | | ALTIMORE N & BROS | | <u> </u> |
| g | Depig Impo any | | Not M. | Cutter | | | | STERSTOWN | | | | | |
| | | | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only | plications that caused one cause on each lir | the death. Do | not enter the m | ode of dyir | ng, such as cardiad | or respiratory | arrest, | | Approxi Interval Onset a | mate Between and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a ather | SCICI a consequence | 20515 |) | | | | | yea | |
| | Examiner | | | - Diak | ettes | oi). | | | | | | uca | rs |
| | D # | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as | a consequence | of): | | | | | | | |
| | executed an and irial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Hypev I | pid CV a consequence | Ma e of): | | | | | | yea | rs . |
| 760, | te be e: ysician ie buria | _ | | d | | | | | | | | | |
| x 6876 | eath certificate be attending physici for use as the bi | Med | IF FEMALE: | 23c. If yes, outcome | of prognancy | | | | | | | Para | |
| O. Box | D O D | Physician/Medica | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal deat | th 3 □Ectopic 5 □ Other (| | <u>,</u> | | | 23d. Date of de Month | Day | Year |
| <u> </u> | The law requires that the deate has been signed by the a sage 2 should be detached for | by Ph | Part II. Other significant conditions | ontributing to death b | ut not resulting | in the underlying | cause giv | en in Part I. | | | use contribute t | | |
| ord | w require been sign | ted I | Lymphoma | | | | | | | | 2 No 3 P | | I∰Onknown |
| Records, | he law has b ge 2 sl | Completed | | | | | | | per | opsy formed? | prior to death? | completion | ngs available of cause of |
| | an: T | Be Co | 25. Was case referred to medical | | | | | 26. Place of Dea | 1 Yes th (Check only | 2 2 N one) | No 1 □ Yes | s 2 No | |
| <u>></u> | Physician: The la r this certificate has ral director, page 2 | To B | examiner? 1 Yes 2 No | | ent 2 ER/O | | 1 | 4 LI Nursing H | | | 6 □Other (Spe | ecify) | 3 |
| ouo | ding F h. After funera | tion: | 27. Manner of Death 1 | 28a. Date of Inju (Month, Da | | Time of Injury M | 28c. Injui Wor 1 □ | yat k? Yes 2∐No | 28d. Describe | now inj | jury occurred | | |
| Division or | or Atten after deat Director: in by the | Certification: | 2 Accident 3 Suicide 4 Homicide | | ury - At home, f c. (Specify) | arm, street, facto | ory, office | | 28f. Location City or To | (Street a | and Number or F ate) | lural Route | Number, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director. | Medical C | 29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar | ysician: To the best niner: On the basis o and manner sta | f examination a | ge, death occurre and/or investigati | ed at the ti on, in my o | me, date and place opinion, death occu | L e, and due to th urred at the time | e cause e, date a | (s) and manner a and place, and du | is stated. le to the cau | ıse(s) |
| | To the within To the compl | Me | 29b. Signature and title of certifier | | 2 | 2 | 9c. Licens | e number | | 29d. D | Date signed (Mon | th, Day, Yea | ar) |
| } | ۸. | | Chyla War | thero I | D_ | / | 1006 | 5959 | | Septe | ember 8 | , 200 | 5 |
| | 10 | | 30. Name and address of person who | DA 3 | eath (Item 23a) | | Kl | Ave Ba | Thurav. | и | (D 212 | 15 | |
| | Sta | ite | 31. Date filed (Month, Day, Year) SFP 1 0 200 | 32. Registr | ar's Signature | South | 100 | | T I LA AFOIC | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 10 -12 | <u>.~</u> | |
| | Registr | ar | SEP 1 0 200 | A STORES | 200 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | 1- State amend #26 Per Phy | G8831.04/16 | 1708 JH ertificate of I | Death | Reg | g. No.2 0 0 8 | 3 28991 |
|-------------------|---|-------------------|--|---|--|--|---------------------------------------|--|---|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | CDI | CHINEVENIA | | 2. Date of Death Month SEPTEMBE | Day Year | |
| and and | /Medic Examin | | NIKOLAY 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | SEPTEMBE | .R 6 200 4c. County of De | |
| * | | | 3 COBBLESTONE COURT, APT. | | BALTI | | | N/ | |
| | Funeral Director | | 5. Social Security Number 220-49-5986 Usual Residence of Decedent | ge (In yrs. last birthda 83 | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 05/10/1 | 9. B 925 | irthplace (State or Foreign Country) UKRAINE |
| | yland ** | | 10a. State 10b. County | 10c. City, Town or | Location | | | | 10d. Inside City Limits |
| | 8a-fs | ctor | MD N/A | BALTI | 1 | | | | 1 🖾 Yes 2 □ No |
| | th with the 23a or 2 | Funeral Director | 3 COBBLESTONE COURT, APT | | | 215 | | g. Citizen of What C | USA |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinational to refilled at once. | | 11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 □ Yes 2 □ If Yes, Give Year or Dates | K No | 3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No | ispanic Origin? (Sp in, Mexican, Puerto Specify: | pecify Yes or No- Rican, etc.) | 14. Race - An Black, Wh Specify: | |
| 21215-0036 | ithin 72 hd ne. nan "natu Medical | Completed by | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or | (G | ecedent's Usual Occup live kind of work done of le. DO NOT use retired | during most of work l) | | 6b. Kind of Busines | |
| d 21 | filed w Hygier Ither th | | 17. Father's Name (First, Middle, Last) | | MECHAN | AUTUIIIL aiden Surname) | DILL | | |
| an | ild be 1 fental rked o iic eve | To Be | | SPICHINEVS | KIY | | OVSKY | | |
| Maryland | 2 should and Mer is marke raumatic | | 19a. Informant's Name/Relationship (Type. Print) | - 1 | ailing Address (Street | | | - | |
| e, Se | 1 and Healtr tem 27 | | YEKATERINA SPICHINEVSKIY , 20a, Method of Disposition | 20h Place of Dis | OBBLESTONE sposition (Name of | | | Oc. Location - City of | |
| <u> </u> | it. Pages rtment of rtant: If ite njury or o | | 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | CHIZUR | AMUNU CON | | | BALTIMORE | |
| Ba | permit. Departr Importa any Inji | | 21. Signatur of Funeral Service License | | | TERSTOWN | ROAD - P | | E, MD 21208 |
| | | Y 16 | 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final | d the death. Do not line. | enter the mode of dyir | g, such as cardiac | | | Approximate Interval Between Onset and Death |
| *** | Physician /Medical | | disease or condition resulting in death) | s a consequence of): | cer, Unix | nowh t | rimari | 1 | |
| | Examiner | | Securifially list couldform. | | | | | 1 | |
| | ig _Gg | Examiner | Couverfially list couldings, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | |
| ó | rificate be executed g physician and as the burial-transit | | resulting in death) Last Due to (or a | s a consequence of): | | | | | |
| 68760, | cate b | ledical | d | | | | | | |
| . Box | death cer e attendir id for use | Physician/Me | | 2 ☐ Fetal death at time of death | 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) | у | | 23d. Date of o | delivery Day Year |
| ds, P. | s tha | þ | Part II. Other significant conditions contributing to death | but not resulting in the | e underlying cause giv | en in Part I. | | | to the cause of death? Probably 4 Unknown |
| Records, | law require as been sig 2 should b | Completed | | | | | 24a. Was an autopsy | 24b. Were | autopsy findings available o completion of cause of |
| <u>=</u> | ilcian: The law certificate has ector, page 2 s | | | | | | perform 1 ☐ Yes 2 | ed? death XNo 1 □ Y | ? es 2□No |
| <u>=</u> | yslcian: nis certific director, p | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpat | tient 2 ER/Outpa | stient 3 T DOA Oth | | th (Check only one | <i>)</i> nce 6 □Other <i>(S_l</i> | nacifu) |
| Division of Vital | ding Phy n. After thii funeral c | Certification: To | 27. Manner of Death 1 Natural 5 □ Pending (Month, D | jury 28b. Tim | e of 28c. Injur | y at | 28d. Describe hov | | recity) |
| Sio | ttendil death. tor: A | icatic | 2 Accident investigation | piury . At home form | | Yes 2 □No | 28f Location (Str. | act and Number or | Rural Route Number, |
| | al or Attend s after death I Director: | ertif | 4 Homicide determined | njury - At home, farm, etc. <i>(Specify)</i> | street, lactory, office | | City or Town, | State) | raia, rioute rumber, |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | Medical C | 29a. Certifier (Check only one) 1 | of examination and/o | | | | | |
| | To the Comp | ğ | 29b. Signature and title of certifier | | 29c. Licens | e number | 29 | ld. Date signed (Mo | |
| | ^ | | * Saba W | wash (m) = 00-1 (T | 1 P000 | 5586 | t | 09/08/20 |)8 |
| - | 5 | | DR. J. SABA, 5 PARK CENT | | SUITE 200, | OWINGS | MILLS, ME | 21117 | |
| t | Sta Registr | | | trar's Signature | fearly) | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **G** O'8 **Physician** 4:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sheffield Road 1556 Battimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 / 10 / 53 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2**X** F 55 MD 218-58-2632 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is a decid Exertine, must be notified. Baltimore MD N/A 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1556 Sheffield Road 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. African 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify: Specify: American 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City of Balt. Elementary/Secondary (0-12) College (1-4or 5+) Crossing Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert H. Braxton Marie Hollie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LaTonya Mountain/Daughter 223 Edge Creek Lane, Odenton, MD 21113 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 9/13/08 Balt.,MD 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State Bayview Cremtory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Funeral Ser 5126 Belair Rd, Balt., MD 21206-5105 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician W disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Exami d'a Due to (or as a consequence of): requires that the death certificate be exe P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 2 🔲 No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar

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(Month, Day,

Year.

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29b. Signatur

29c. License numbe

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanirar must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical 8/30/08 @0915 Examiner Division of Vital Records, P.O. Box 68760. Herman E. Smith

1 - For State Registrar 1. Decedent's I

Day, Year) 102008

Be Completed by Funeral Director

ျှ

Physician/Medical Examiner

Medical Certification: To Be Completed by

Physician /Medical

Examiner

Funeral Director

| _ State Registrar | | | | Certificate of | Death | Reg | No. 2008 | 28993 |
|--|--|---------------------------------|--|--|--|---|---|--|
| Decedent's Nam | e (First, Middle, | Last) | | | | Date of Death Month | Day Year | 3. Time of Death |
| | | | Herman Sr | nith | | Au | g 30, 2008 | 0915 |
| Facility Name (| f not institution, | give street and nu | ımber) | 4b. City, Town, | or Location of Death | | 4c. County of Death | |
| | | seph Richey | Hospice, Inc. | | | 8. Date of Birth | | N/A |
| Social Security Number 6. Sex 7. Age | | | 7. Age (In yrs. last birti | Months Days Hours Min. | | | ear) Coi | nplace (State or Foreign untry) |
| | 2-1907 | X | 79 | rs. | | May 13, | 1929 | Maryland |
| ual Residence o | 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| Mondond | | N/A | | | Baltimore | | | 1 □ X es 2 □ No |
| Maryland B. Street and Nur | mher | 19/74 | | 10f. Zip Code | Daidinors | 10a | . Citizen of What Cor | untry? |
| | _ | | | | 21216 | | | S.A. |
| | burton Stre | | edent Ever in U.S. | 13 Was Decedent of | | ecify Yes or No- | 14. Race - Amer | |
| Marital Status | ied 2□ ⊌ arrie | Armed Fo | orces? | 13. Was Decedent of If Yes, specify Cul | an, Mexican, Puerto | Rican, etc.) | Black, White | |
| 3 Widowed | _ ^ | If Yest, Gi Year or D | ive 1950 | 1 □ Yes 2 □ Nyo | Specify: | | Specify: | Black |
| | 15. Decedent's | | 1952 16a. | Decedent's Usual Occu | | | b. Kind of Business/l | ndustry |
| | cify only highest | grade completed) | | (Give kind of work done life. DO NOT use retire | during most of worked) | ing | 0 | um Dairt |
| Elementary/Seco | nigary (U-12) | College (| 1-40[5+) | Ship | ping Checker | | Sparro | ows Point |
| . Father's Name | (First, Middle, La | ast) | , | | 18. Mother's Nam | e (First, Middle, Ma | den Sumame) | |
| | Cfi | nton Smith | | | | Marg | aret Taylor | |
| a. Informant's N | ame/Relationshi | p (Type. Print) | 19b. | Mailing Address (Stree | t and Number or Rui | ral Route Number, C | ity or Town, State, 2 | (ip Code) |
| Helen Si | nith Wife | | | 2300 Ashbu | ton Street Bal | timore, Maryla | nd 21216 | |
| a. Method of Dis | | | 20b. Place of | Disposition (Name of | 1 | | c. Location - City or | Town, State |
| | ☐ Cremation 3 5 ☐ Other (Spe | Removal from | State | v, crematory or other pla | i | 09/08/08 | Owings | Mills, Md. |
| - + H | meral Service Li | 1 | Garns | on Forest Vetera | | 00,00,04 | | |
| | MI | 771 | 75/02 | Ester | Brothers Fun | eral Service, F | P. A. | |
| Ba. Part 1. Enter t | he disease, or c | omplications that | caused h death. I n | 1300 | Eutaw Place | latimore Md | 21217 | Approximate |
| shock, or hea nmediate Cause | irt fallure. List of | nly one cause on | 11/2/1 | Mush | M7 | , | 1 | Interval Between Oneet and Death |
| sease or condition sulting in death) | n | -a/// | 11/10/2 | rivejoi | | | | //// |
| <i>j</i> | | Dua to | (ras consequence o | f):/ | | | | |
| | | | | Α. | | | | <u> </u> |
| equentially list co | nditions, | b | / | | | | | |
| equentially list co any, leading to in use. Enter Unde | nditions, imediate erlying | b. Due to | (or as a consequence o | r): | | | 7.1 | |
| any, leading to imuse. Enter Under use. Enter Under use (Discussion) at initiated events | imediate rlying injury | С | | | | | /4 | |
| any, leading to im luse. Enter Under luse (Lissass of at initiated events | imediate rlying injury | С | (or as a consequence o | | | | - /1 | |
| any, leading to im ause. Enter Under ause (Dissass of nat initiated events | imediate rlying injury | С | | | | | <i>h</i> | |
| equentially list co any, leading to in ause. Enter Unde ause (Jis ass J at initiated events ssulting in death) | imediate rlying injury | c Due to | (or as a consequence o | | | | | |
| any, leading to in use. Enter Unde use. Enter Unde use (_1s as J at initiated events sulting in death) FEMALE: Bb. Was deceden | imediate rifying injury Last | c | | | су | | 23d. Date of del | |
| ny, leading to imuse. Enter Under U | Imediate riflying injury state and the state | c | (or as a consequence of the consequence of the consequence of pregnancy birth 2 ☐ Fetal death the consequence of the consequen | f): | су | | 23d. Date of del Month | ivery Day Year |
| in leading to imuse. Enter Und | t pregnant months? | c. Due to d. 23c. If yes, ou 1 | (or as a consequence of the control | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | | | Month | Day Year |
| iny, leading to imuse. Enter Und | t pregnant months? | c | (or as a consequence of the consequence of the consequence of pregnancy birth 2 ☐ Fetal death the consequence of the consequen | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | | | Month | Day Year the cause of death? |
| in leading to imuse. Enter Und | t pregnant months? | c | (or as a consequence of the control | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | | 23e. Did tobac 1 □ Yes | Month | Day Year the cause of death? |
| in leading to imuse. Enter Und | t pregnant months? | c | (or as a consequence of the control | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | | 1 ☐ Yes 24a. Was an | Month co use contribute to 2 No 3 Pr | the cause of death? obably 4 (I) Inknown topsy findings available |
| iny, leading to imuse. Enter Und | t pregnant months? | c | (or as a consequence of the control | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | | 1 ☐ Yes 24a. Was an autopsy performe | Month 2 No 3 Pr 24b. Were au prior to a death? | the cause of death? obably 4 7 Wiknowr topsy findings available completion of cause of |
| any, leading to in use. Enter Und | t pregnant months? | c | (or as a consequence of the control | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | ven in Part I. | 1 ☐ Yes 24a. Was an autopsy performe 1 ☐ Yes 2 | Month 2 No 3 Pr 24b. Were au prior to death? | the cause of death? obably 4 Anknown |
| in leading to limit with the leading to limit and events sulting in death) FEMALE: b. Was deceden in the past 12 1 Yes 2 9 Unknown rt II. Other signi | t pregnant months? | c. Due to d. 23c. If yes, ou 1 | (or as a consequence of the control | f): 3 ☐ Ectopic pregnar 5 ☐ Other (specify) the underlying cause gi | ven in Part I. 26. Place of Deat | 1 Yes 24a. Was an autopsy performe 1 Yes 2 | Month 2 No 3 Pr 24b. Were au prior to death? 1 Yes | the cause of death? obably 4 A Minowr topsy findings available completion of cause of |
| iny, leading to live. Enter Underse. Classes of the last of the la | t pregnant months? | c | (or as a consequence of the cons | f): 3 | ven in Part I. 26. Place of Deather: 4 \(\to \) Nursing Houry at | 1 ☐ Yes 24a. Was an autopsy performe 1 ☐ Yes 2 | Month 2 No 3 Pr 2/15. Were au prior to death? 1 yes | the cause of death? obably 4 A Microwittopsy findings available completion of cause of |
| in y leading to imuse. Enter Under U | t pregnant months? No rea to medical No h 5 □ Pending | c | (or as a consequence of the cons | f): 3 | ven in Part I. 26. Place of Deather: 4 □ Nursing Houry at | 1 Yes 24a. Was an autopsy performe 1 Yes 2 in (Check only one) ome 5 Residence | Month 2 No 3 Pr 2/15. Were au prior to death? 1 yes | the cause of death? obably 4 A Minowr topsy findings available completion of cause of |
| in leading to imuse. Enter Und | t pregnant months? No ficant condition | C. Due to d. 23c. If yes, ou 1 | (or as a consequence of the cons | a Ectopic pregnar b Other (specify) the underlying cause gi patient 3 DOA of the policy of the pol | ven in Part I. 26. Place of Deather: 4 \(\to \) Nursing Houry at | 1 Yes 24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how | Month 2 No 3 Pr 2/15. Were au prior to death? 1 yes | the cause of death? obably 4 Almknown topsy findings available completion of cause of 2 No |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| - / W | | | | | | |
|--|--------------------------------|---|-----------------------------|---|---|------------------------|
| 27. Manner of Death 1 ☐ Natural 2 ☐ Accident | 5 Pending investigation | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how injury occurred | 110110 |
| 3 Suicide 4 Homicide | 6 ☐ Could not be determined | 28e. Place of Injury - At he building, etc. (Specif | ome, farm, street, factory) | ry, office | 28f. Location (Street and Number City or Town, State) | or Rural Route Number, |
| | | | | | e, and due to the cause(s) and man urred at the time, date and place, an | |
| 29b. Signature and ti | itle of certifie | (M) | 2 | 9c. License number | 29d. Date signed (| Month, Day, Year) |
| 30. Name and address | person who con | npleted cause of death (Ken | n 2834 (Type, Priht) | A Ba | 11/11/2/2 | 18 |
| 31. Date filed (Month | Day, Year) | 2. Registrar's Signa | ture | | , , , , | |

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Vrablic 4:45 PM DIOria /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F Director 212-30-7362 June 4,1932 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Eventher must be notified as 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2040 Kelmore Road 21222 by Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-6036 1 ☐Yes 2 ☐No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 11 Years School Bus Attendant Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental George T. Duff ပ Helen A. Lilly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Judith Brown (Sister) 1248 Willow Road Dundalk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Deponation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns 9/09/2008 Timonium, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, MD 23a. Part 1. Enter the disease, — omplications that caused the death. Do in — ter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): infarction disease or condition resulting in death) minutes /Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and -transit that the death certificate be executed physician are the burial-t Due to (or as a consequence of) Physician/Medical asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death for in the past 12 months? Month 5 Other (specify) □Yes 2 0 signed by the a o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ been signature should b 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy page certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After or Attending Natural Injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 ☐ Homicide filled in within 24 hours a

To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and tiple of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Robert

31. Date filed (Month, Day, Year)

Hallon

ORIGINA

Johns

both walfe street.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Vear **Physician** CURTIS ROOSEVELT VIA 11:30P M SEPT 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Yrs. 73 10/27/1934 234-49-7128 VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County ms 23s or 28a-f shortmast be notified at 1X Yes 2 □ No WESTMINSTER MD CARROLL Director the 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21157 or Items 23g 350 N. COLONIAL AVE. USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. traumatic event, the Medical Examiner 1∑|Yes 2 | No 1958 |fYes, Give Year or Dates: 1960 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING STEEL WORKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) os 1 and 2 should be fi of Health and Mental H item 27 Is marked of WILLIAM KING VIA CORA BELLE HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 350 N. COLONIAL AVE., WESTMINSTER, MD 21157 WIFE VIRGINIA L. VIA 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 இ Purial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Donation 5 Other (Specify) LAKE VIEW MEM. PARK 9/12/08 ELDERSBURG, MD at 31 Full graf Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Element the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SDIRATION anstant Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ winar 0 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 LNO Division of Vital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending r death. investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I 29a, Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100 8 2-0C

State Registrar

CHITRACHEDU 31. Date filed (Month, Day, Year) SEP 1 0 2008



h)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

pode Pd, west minter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year VINCENI **Physician** 02+21-AM eptember 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hoirbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛣 F Maryland **Director** 213-72-9295 30, 1960 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than matic event, IPs Mixical Extr. 1 as 1 be notified at any injury or other traumatic event, IPs Mixical Extr. 1 or 1 as 1 be notified. 10b. County 1 ☐Yes 2 XNo Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7813 East Road 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖺 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Ceramics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent ဂ္ Henry Ruth Μ. Evers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Jenne - son 7813 East Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2008 Baltimore, MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Cedar Hill Cemetery Sept. 11, 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licensee <u> 311 Mountain Rd. Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lailure respirator **Physician** /Medical Due to (or as a consequence of): Examiner rosersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) neumo sepsis attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death. When the forest per death of the funeral Director: After this certificate has been signed by the attending physician for the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buring Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diastolic OPD 1 ☐ Yes 2 No 3 Probably 4 Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2/5 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1-XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jahne 1

Tinoco

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

29c. License number

001

RES

3001 South Hanover Street Baltinok,

29d. Date signed (Month, Day, Year)

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #31 Per DVR G883 9/10/08 JH Certificate of Death Reg. No. Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Wilson 2008 polember ear /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** saltimore 9. Birthplace (State or Foreign North Carolina If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🖫 F Days Hours Min. Carolina 240-54 une 114 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be netified at any Injury or other traumatic event, the Medical Examiner must be netified at any Injury or other traumatic event, the Medical Examiner must be netified at any Injury or other traumatic event. 1 ☐ Yes 2 ☐ No Itimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 501 reston 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No If Yes. Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ Mo Specify. Black Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) rovider Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be iams telia ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) NE Washington, Powhatan Place. 560 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore. 10/08 remator 4 ☐ Donation 5 ☐ Other (Specify) Funeral 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-translt Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by Yes 2 No 3 Probably 4 Unknown icate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 5 Residence 6 □Other (Specify) Other: 2 No 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending Injury Natural 2 Accident 1 ☐Yes 2 ☐ No investigation Director: A 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier P25662 29d. Date/signed Month, Day, Year) 29b. Signature and title of certifier 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 3333 N. CALVERTST #54021218 REGORY 3 31. Date filed (Month, Day, Year) 32. Registras Signature State SE

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:30 A M SEPTEMBER 5, 2008 LOUISE WASHINGTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SHAMROCK HOME PRINCE GEORGE'S CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days Min. 1 ☐ M 2 🗓 F

10f. Zip Code

20735

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

AUG 9,

1906

USA

NY

14. Race - American Indian

BLACK

20735

23d. Date of delivery

1 ☐ Yes

29d. Date signed (Month, Day, Year)

20735

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Month

20746

Approximate Interval Between Onset and Death

Black, White, etc.

10g. Citizen of What Country?

Specify:

10d. Inside City Limits

1X Yes 2 ☐ No

Funeral

579-05-8009 Usual Residence of Decedent

10e. Street and Number

11. Marital Status

10a. State

MD

10b. County

9008 SPRING ACRES ROAD

1 ☐ Never Married 2 ☐ Married

PRINCE GEORGE'S

Director show d other than "natural", or items 23a or 28a-f shorevent, the Medical Evantiner must be motified at Director Funeral should be filed within 72 hours after und Mental Hygiene. marked other than "natural", or iter ≥ Completed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event sonce. Be ပ

Maryland 21215-0036

Baltimore,

Box 68760;

P.0.

Division of Vital Records,

Physician /Medical Examiner

be executed sician and burial-trans attending physician for use as the burial signed by the a peen has certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral the filled in by To the Hospital or within 24 hours at To the Funeral D

1 □Yes 2X No Specify 3 X Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GEORGETOWN UNIVERSITY CUSTODIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9008 SPRING ACRES ROAD CLINTON, MD LEOLA KELLY / GUARDIAN 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HARMONY MEMORIAL PARK 09-10-2008 LANDOVER, MD 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature neral Servi e Lic-nsee SUITLAND, MD DONALD R. GRAY 4308 SUITLAND ROAD 23a. Part f. Pinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24a. Was an autopsy performed 1 ∐Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Assisted Living Facility Hospital: 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

102

10c. City, Town or Location

CLINTON

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of dentifier

PUSHMA SAMTANI

SFP10

31. Date filed (Month, Day, Year)

PISCATAWAY ROAD SUITE 280

29c. License number

CLINTON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 8, 2008 5:00P Saundra Anntonette Wells /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Air Vear | If Under 24 Hrs. | Min. Harford Upper Chesapeake Medical Center Bel Birthplace (State or Foreign Country) Security Number 8. Date of Birth **Funeral** Months Davs Hours 1□M ¾□F 217-34-6918 Director November2,1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8805 Baker Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Deli Manager and Mental Hygiv 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) be Frank Kramer Edna Bowen 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly K. Wieteha/Daughter 8805Baker Avenue, Baltimore, Maryland 21234 injury or other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 N Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State View Cemetery 9-12-08 West Friendship, MD. 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael ! margullo 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS /Medical Due to (or as a consequence of): ANGURYSM Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 robably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasan Birbaum, M.D. 500 Upper Chesapeake Dr. Bel 4ir, MD 21014
Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Physician/ al Examiner | Red | nistrar Decedent's Name (First, Middle,Last) | | ertificate o | Dodan | | 2. Date of Death | | 3. Tin | ne of Death | |
|--|--|--|--|---|--|---|---|--|--|--|--|
| ai Lamiiiici | | William T. Whit | taker | | | | Month August 22, | | | 944 hrs | |
| 7 | 4a. | Facility Name (if not institution, give s | | N. | • | Location of Death | | 4c. County | | | |
| | L | Washington County Hospita | | | Hagerstown | | | Washing | _ | 10 | |
| Funeral Director | | Social Security Number 1912 6. Sex 220-84-9620 | 7. Age (In yrs | . last birthday) 44yrs | Months Day | | Apr 19 | , 1964 | Country) Maryla | | |
| any | - | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. | | | | | | | | Inside City Lim | |
| * | MD Washington Hagerstown | | | | | 1 Yes 2 | | | Yes 2 X | | |
| after death with the Maryland al", or items 23a or 28a-f sho tirer must be notified at once. by Funeral Director | 10 | 10e. Street and Number 13 Burger Avenue | | | | 21740 τ | | | hat Country? | | |
| r death with or items 23 must be no Funeral | | Marital Status Never Married 2 Married | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 XX No | unk f | Yes, specify Cuba | spanic Origin? (Sp n, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | e - American In e, etc. | | |
| s after rail", o | `L | | f Yes, Give Year or Dates: | | Yes 2 X No | | 11010 | Specify: | white | | |
| hours fram Exam | 1 | 5. Decedent's Education (Specify only | highest grade completed) College (1-4 or 5+) | 16a. Decede during n | nt's Usual Occupa nost of working life | ation (Give kind of v e. DO NOT use reti | vork done UIIK red) | 16b. Kind of Bi | usiness/Industi | y unk | |
| ed within 72 hour lygiene. other than "natu the Medical Exan | | Elementary/Secondary (0-12) RK 8 | nk | Help | er | | | Constr | uction | | |
| ygiene ygiene yther he Me | 17 | Father's Name (First, Middle, Last) | | | water | 18.Mother's Name | • | | | un | |
| be file ntal H rked c | | Kelly Clinton W | hittaker | | | Maude I | illian : | Branhan | L | | |
| hould and Me is ma | 19 | a. Informant's Name/Relationship (Type O C M . E | oe, Print) | | | et and Number or I | | | | | |
| nd 2 s alth ar m 27 raums | 20 | Sarah D. Bramme | | | sition (Name of co | ect Balko | Date Date | 20c. Location | - City or Town | - | |
| permit. Pages I and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturinjury or other traumatic event, the Medical Examinjury or Other Traumatic | 1 4 | Burial 2 Cremation 3 Donation 5 X Other Specify: | Removal from State | crematory or o | ther place) | | | | | | |
| permit. Departi Import | 21 | . Signature of Euneral Project icent. | Directo | | | s of Facility Comy Boar | | Baltin | nore St | reet | |
| hysician /Medical | | ia. Fart I. Enter the disease, of complic fature. List only one cause on eac mediate Cause (Final disease a. | cations that caused the dea h line. Acute ethano | th. Do not enter | the mode of dying | MD 212 , such as cardiac c | r respiratory arre | st, shock, or he | eart Ap Be | proximate Inte tween Onset Death | |
| `xaminer | Se | equentially list conditions, any, leading to immediate D | ue to (or as a consequence | | | | | | | | |
| uted d ansit | (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. | | | | | | | | | | |
| nte be executed hysician and e burial - transit | X UNPENDED 23a. 27, 28a-f, per ME g883 9/11/08 TT | | | | | | | | | | |
| aw requires that the death corificate b as requires that the attending physical should be detached for use as the but pleted by Physician/Mee | IF 231 | FEMALE: b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown | 23c. If yes, outcome of pr 1 Live birth 4 Pregnant at time of | 2 F | etal death 3 | Ectopic pregna | ancy | 23d. Date of Month | of delivery Day | Year | |
| by the a | ╎ | | 9 Unknown | ot resulting in the | underlying cause | given in Part I. | 23e. Did to | bacco use con | tribute to the ca | ause of death | |
| that that detac | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 1 Yes | 1 Yes 2 No 3 Probably 4 V Unknow | | | |
| een sig | | | | | | | 24a. Was | | Were autopsy | | |
| | - | | | | | | autop | med? | prior to compl death? | - | |
| law re has be 2 sho | i I | | | | | | 1 🗸 Yes | 2 No | 1 🗸 Yes | 2 N | |
| The law require fifcate has been sig r, page 2 should b | 0.00 | 16/ referred to modical | | | 26 Plas | ce of Death (Check | only one) | | | | |
| sician: The law re s certificate has be irector, page 2 sho | 3 25 | | ospital: 1 Inpatient 2 | ✓ FR/Outpatier | yann. | Other Nursi | | Residence 6 | Other: | | |
| Physician: The law re ter this certificate has be real director, page 2 sho | 25 | | 28a. Date of Injury | ✓ ER/Outpatier | nt 3 DOA | Othor | | Residence 6 | | | |
| inding Physician: The law reading the structure of the certificate has been funeral director, page 2 should be 100n: To Be Comple | 25 | examiner? 1 ✓ Yes 2 No 7. Manner of Death Natural 5 Pending | 28a. Date of Injury (Month, Day,Year) | 28b. Time of | nt 3 DOA | Other Nursi | ng Home 5 | | | | |
| ratending Physician: The law re redeath. irector: After this certificate has be noy the funeral director, page 2 she fication: To Be Comple | 25 | examiner? 1 ✓ Yes 2 No 7. Manner of Death Natural 5 Pending Investigatio | 28a. Date of Injury (Month, Day, Year) Fnd 8/22/0 28e. Place of Injury - A | 28b. Time of 8 Fnd 7 t home, farm, str | nt 3 DOA Injury 28c. In | Other Nursi | 28d. Describe tunk 28f. Location (S | now injury occu | rred | oute Number | |
| Invision of vical records, i.e., but one of the death certificate be used a classificate between the death certificate be used for this certificate has been signed by the attending physicilled in by the funeral director, page 2 should be detached for use as the bursertification: To Be Completed by Physician/Med | 25 | examiner? 1 ✓ Yes 2 No 7. Manner of Death Natural 5 Pending Investigatio Accident 6 Could not be determined | 28a. Date of Injury (Month, Day, Year) Fnd 8/22/0 | 28b. Time of 8 Fnd 7 t home, farm, str | nt 3 DOA Injury 28c. In | Other Nursi | 28d. Describe i | now injury occu | rred ber or Rural R | | |
| o the Hospital or Attending Physician: The law retifine 24 hours after death. o the Funeral Director: After this certificate has by ampletely filled in by the funeral director, page 2 she edical Certification: To Be Comple | 27 1 2 3 4 20 | examiner? 1 Yes 2 No 7. Manner of Death Natural 5 Pending Investigatio 6 Could not b determined 13. Certifier 1 Certifying Physicia Physicia 2 Medical Examiner: | 28a. Place of Injury (Month, Day, Year) Fnd 8/22/0 28e. Place of Injury - A (Specify) house In: To the best of my know on the basis of examination | 28b. Time of Record 18 Fnd 7 thome, farm, str | Injury 28c. Injury | Other Work? Yes 2 X No building, etc. | 28d. Describe I unk 28f. Location (\$ or Town, S 13 Burg | ow injury occu street and Num tate) er Ave e(s) and manne | ber or Rural R Hagers er as stated. | town, | |
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| To the Hospital or Attending Physician: The law re within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 she Medical Certification: To Be Comple | 27 1 2 3 3 4 2 9 (Coor | examiner? 1 V Yes 2 No 7. Manner of Death Natural 5 Pending Investigation 2 Accident 6 X Could not be determined 3a. Certifier 1 Certifying Physician Check only 2 Medical Examiner: 3b. Signature and title of certifier 3b. Signature and address of person who could be determined | 28a. Date of Injury (Month, Day, Year) Fnd 8/22/0 28e. Place of Injury - A (Specify) house In: To the best of my know On the basis of examinatio and manner stated. | 28b. Time of Record 18 Fnd 7 thome, farm, structure and the record 18 feet 18 | 28c. In 28c. I | Other Mursi | 28d. Describe I unk 28f. Location (5 or Town, S) 13 Burg d due to the caus at the time, date | Street and Num tate) er Ave e(s) and manneand place, and | ber or Rural | town, | |
| To the Hospital or Attending Physician: The law re within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 she Medical Certification: To Be Comple | 27 1 2 3 3 4 2 9 (Coor | examiner? 1 V Yes 2 No 7. Manner of Death Natural 5 Pending Investigation 2 Accident 6 X Could not be determined 3a. Certifier 1 Certifying Physician Check only 2 Medical Examiner: 3b. Signature and title of certifier 3b. Signature and address of person who could be determined | 28a. Date of Injury - A (Specify) house In: To the best of my know On the basis of examinatio and manner stated. | 28b. Time of 8 Fnd 7 t home, farm, str ledge, death occur and/or investig | 28c. In 28c. I | Other Wursi Other | 28d. Describe I unk 28f. Location (5 or Town, S) 13 Burg d due to the caus at the time, date | Street and Num tate) er Ave e(s) and manneand place, and | ber or Rural | town, | |